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ABSTRACT

Ten authors' viewpoints about preparing healthy children for possible hospitalization are presented. Selected topics include (1) the fallacy of "preparing" young healthy children for possible hospitalization, (2) parents as the best preparers of young children, (3) preparing young children for unplanned hospital admissions, (4) anxiety created when young children tour hospitals, (5) engendering positive feelings about hospitals and health care, (6) program models for preparing healthy children for hospitalization, (7) preparing children for hospitalization, (8) preventing distress once the child is in the hospital, (9) children's handling of difficult events, (10) information about nonpatient preparation by three child advocacy groups, and (11) practices and studies in nonpatient preparation. Bibliographies for adults and young children are included. The board of directors and advisory board members of pediatric projects are listed. (BJD)

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PREPARATION OF YOUNG HEALTHY CHILDREN FOR POSSIBLE HOSPITALIZATION: THE ISSUES

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Monograph No. 1

PREPARATION OF YOUNG HEALTHY CHILDREN FOR POSSIBLE HOSPITALIZATION: THE ISSUES

Edited by Pat Azarnoff

Monograph No. 1 Pediatric Projects Inc

Dedication photograph by Karl Guttmann
Production by Barbara Menkes

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Dedication

Berta Plaut was the first play therapist in Los Angeles hospitals. Born in Austria she trained with Anna Freud and worked in the war nurseries in London before travelling, eventually, to the United States. After her retirement from the Play Therapy Program at Cedars of Lebanon Hospital (now part of Cedars-Sinai Medical Center in Los Angeles) Mrs. Plaut volunteered to develop a similar program at Kaiser Foundation Hospital-Sunset, in Los Angeles, devoting almost full time to that effort.

A major involvement of hers was the development of preparation methods and materials for patients and prospective patients. She designed and built miniature hospital furniture, medical equipment replicas, puppets, and dolls and their clothing. She tried verbal and nonverbal methods of reaching children with these materials, considered their developmental issues, and was always concerned that she say enough but not too much, the "right" things and not anxiety-producing information, at the "right" time.

She would have appreciated being part of the discussion in this monograph and could have offered thoughtful and sensitive insights about children as she always had.

We appreciate the contributions of donors to the Berta Plaut Memorial Fund of Pediatric Projects Inc that helped to make this publication possible and wish to dedicate the monograph to Berta Plaut for her long and full devotion to children's emotional life.

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INTRODUCTION

Now that hospitals are becoming more open to the public, a visit to a hospital seems like a nice thing to do for children--just as they visit the fire house, post office, and market. Or is it?

There are many preparation programs for young children in United States hospitals and preschools. In South Australia a hospital play kit was widely distributed to kindergartens. Child advocates in England have sponsored many visits to schools and play groups. Some Canadian hospitals have offered nonpatient tours.

What do we know about children's development that can help us decide about such programs? What do we know of children's inner life that can help us understand them? What do we know of children's cognitive growth that can help us teach appropriately?

In this monograph Joyce Robertson, a early leader (with her husband, James Robertson) in promoting parents' access to their hospitalized children, calls attention to current practices in

the preparation of young nonpatients. She cautions that hospital tours and preschool education about hospitals are well-intentioned but harmful programs for children. She urges reconsideration of preparation for nonpatients, more research about it, and an emphasis on parents' right to prepare their own children when and how they want.

It is important to bring up these views about the impact on young children of preparing them for stressful events and to consider the issues. The leadership of the Robertsons and of the National Association for the Welfare of Children in Hospital in encouraging this discussion is appreciated. Other leaders involved in the emotional care of young children have, in the interest of generating discussion and research, contributed to this monograph significant papers with various points of view.

Susan Harvey, who has stimulated the educational progress of play leaders and the growth of professional play programs in England, writes of the need to have only parents talk and play with their young children about hospitals. Preschools and play groups should have medically-oriented toys for children to use but should not direct children's learning about hospitals. Her discussions with professional groups, such as the British Association for Early Childhood Education, the National Association of Hospital Play Staff, the Save the Children Fund, and the Pre-School Playgroup Association, have encouraged her to believe these views are widely held by other child development specialists in England.

Juliet Hopkins, of the Tavistock Child Guidance Training Centre, agrees that preparation of nonpatient children should be avoided. She argues that such activities create unnecessary anticipatory anxiety and adds to the intense anxiety which is a part of children's normal development. While preparation may be helpful to children who are actually going to be patients, it is

not helpful to those who may never be patients.

Carole B. Klein, who heads a long-established child life program, suggests that hospital tours are not appropriate for youngsters who might see unplanned-for sights and hear the hospital sounds that adults no longer hear. She and her staff (as well as other child life workers in her city) have had an opportunity to offer hospital tours and have seen first-hand how upsetting such tours can be to children despite the most careful planning. Instead, a preschool education program is offered in which children can handle medical equipment and instruments and talk about their experiences, thoughts and feelings.

Mary Evans Robinson, a pediatric psychologist who directs a major child life program, also tried nonpatient hospital tours but concluded that preparation of young nonpatient children was preferable in the preschools. Her program sends trained volunteers to the youngsters in schools, where they can see and discuss large photographs of hospital events, handle medical materials, and tell and listen to stories.

Patricia L. Mather, who directs a university training program for child life workers, conducted studies of nonpatient preparation programs offered in community preschools. She concluded that the use of a brief puppet show, discussion of children's concerns, opportunities to handle medical objects, and other aspects of the preparation protocol were effective in increasing children's knowledge, and that children responded positively to the program. She recommends in-school sessions that are appropriately planned for the age group as an alternative to or preparation for hospital tours.

Carol Hardgrove-Aldrich, long an advocate for parents and their children in health care, has reservations about hospital tours, except when certain conditions are met or for certain

nonpatients. However, she believes education in preschools can be beneficial. She alerts teachers to interview and prepare speakers before they talk with the children and that the children's preparation sessions be planned as multi-sensory events. She details aspects of the preparation session to consider. She also believes in the rights of parents to prepare their own children but feels that hospitals, like sex, are not discussed in some homes and therefore become a taboo subject.

Graham Martin, a child and family psychiatrist who was with Adelaide Children's Hospital, is an advocate for emotional support of children and parents in health care. He emphasizes that giving information to children about health and illness events is a form of psychological prevention, but developing the appropriate materials for the preventive work takes practice. He acknowledges that preparation raises children's anxiety. However, Dr. Martin believes that "some anxiety is necessary for the working through of an experience, but that if such anxiety-provoking experiences are satisfactorily worked through, then the long term anxieties are reduced."

Patricia Lindquist, a psychologist in private practice who has studied special aspects of children in health care, believes that nonpatient children can tolerate and benefit from preparation in hospitals, preschools, or at home. She explains the growth of coping techniques in children under five years of age. Dr. Lindquist maintains that children's natural defenses will protect them from too much anxiety, especially if information and experiences are offered in tolerable doses and added to a little at a time. Preparation should not be given once but regularly. "Each time over difficult ground children can bring their versions of things closer to reality."

The views of the three major child advocacy organizations on pediatric psychosocial care in the United States, England and

Australia are reported, to indicate the trends and current thought. And, finally, I have tried to summarize some of the practices and research in several countries. Some of the people interviewed were enthusiastic about hospital tours and/or visits of staff to schools and felt their work was effective with children when the tours and visits were thoughtfully planned and carried out. Others felt differently. Few programs are systematically evaluated or their long-term effects on children studied. Most decisions about them are based on reasoned clinical judgment and child development theory. Readers will find a diversity of opinion here to help them think through the issues and decide for themselves.

For the purposes of this monograph "young children" are three- to seven-years-of-age. "Preparation" is information and emotional support that focuses on ideas and feelings about the medical experience prior to the time of those experiences. "Nonpatients" are those children who are not now patients and who have no immediate prospect of being patients at the time of the preparation.

Pediatric Projects Inc is pleased to be able to publish the views of these authors. As a nonprofit corporation our purpose is to develop and distribute mental health materials to people who work for children and families in health care. We appreciate the contributions of the distinguished authors in this monograph toward that effort.

Pat Azarnoff
Santa Monica, California
1983

The Fallacy of "Preparing" Young Healthy Children for Possible Hospitalization

by Joyce Robertson

Child Psychologist, Robertson Centre
London, England

During the past twenty years there have been increasing attempts throughout the Western world to find ways of softening the experience of being in hospital for young children. Initially the main objective was to obtain unrestricted visiting to all children and to ensure that parents of under-fives could stay in hospital with them in order to help in their care and prevent the dangerous distress commonly seen in young children who go into hospital alone. (1, 2)

In recent years activity has extended beyond the sick child in the hospital ward to healthy children in the community. Attempts are being made to inform all young children about hospitals. The hope is that children thus "prepared" who go into hospital will be better able to cope than if they had not had the

benefit of foreknowledge.

Young children from play groups and infant schools have been taken on tours of children's wards, told what happens there, and shown some of the treatment procedures. Speakers from voluntary organizations visit play groups and infant schools to talk to the children about hospitals, using books, slides, films and toy medical instruments to illustrate blood taking, injections and other procedures. (3)

These well-intentioned projects are misconceived, unnecessary, and potentially harmful. They assume that the children will be reassured by what they are told. But this educational approach neglects the fact that in the early years children are coping with fantasies, labile emotions, and limited comprehension. Talks about hospitals, with their undertones of separation and hurt, may impinge with disturbances for children.

WHAT DOES "HOSPITAL" MEAN TO THE YOUNG CHILD? To a young child "hospital" can mean being on a visit to a big building where strange things are seen, smelled and heard. It can mean being ill, perhaps in pain, where there are doctors and nurses who interfere with or hurt one's body. It can mean being in a strange place away from home and the people one is dependent upon. It can mean feeling frightened, confused and having a limited understanding of what is happening.

Hospital is a subject which cannot be divorced from worrying feelings. Adults and older children can understand the need for hospital and are glad of the help given. But very young children cannot understand why they should be ill or in pain; they are additionally made specially anxious by the threat to their bodies.

Young children are not unaware of illness, pain, and

hospitals. In the course of family life they gradually come to know about being ill, getting medicine, hurting themselves, getting a plaster, going to the clinic, seeing the nurse, and having the doctor visit them at home. They see hospital buildings and ambulances and gradually learn their purpose in the haphazard way young children learn. The pace at which the picture is added to will depend upon the children's ages and personal experiences; the family's experiences of illness, accidents, birth and death; and what happens to the children's playmates.

Examples of such learning follow:

1) Before Sarah was two years old her father injured his back and went to the local hospital. When she was taken to visit she saw that people were in bed and got their dinner there, that doctors and nurses looked after them and made them better. Then they went home, as her father did. That bit of learning was tied to immediate experience. Sarah's play reflected her anxieties and her limited understanding. Her mother helped her to work through them.

At three years of age she had an eye infection and was taken twice to outpatients. Her "preparation" was simple. She was told by her mother that she was going to the hospital where a doctor and nurse would look at her eye. The mother explained and comforted as needed. Sarah did not like the eye drops or the patch over her eye and said so. Afterwards there was much play about the visit, putting patches on her teddy bear's eyes and telling her daddy about it. There was appropriate anxiety to be talked through such as why it had happened, what the doctor had done and how the eye would get better.

The return visit to the outpatients a week later was unwelcome to Sarah but was accepted as necessary. More play and

talk followed, about eyes and only about eyes, the subject of Sarah's anxiety.

Her other hospital experience was to visit a maternity ward to see a neighbor's new baby. This appeared to put no strain on her. Sarah's knowledge about hospitals had increased but it was still limited to her experiences and was under the control of her parents.

2) At three years of age Paul, Sarah's friend next door, visited his mother in the maternity unit, his first experience of hospital. Some months later he saw Sarah's eye patch and was told about her visit to the hospital where the doctors had made her better. He joined in the play with eye patches. Both mothers were on hand to correct confusions and to cope with anxieties that arose from the children's play and talk.

At four years of age Paul cut his head and was taken to outpatients. He complained bitterly as he was held and stitched. Comforting at the time, and play and talk afterwards, increased Paul's understanding of what hospital is for. His knowledge about hospital is still limited but is reality-based and age-adequate. Unavoidably he is left with some anxiety.

Sarah and Paul sometimes play at doctors and nurses, but there is much that these two children do not know about hospitals. The parents avoid many of the illustrated books on hospitals since these open up anxiety-making issues which they feel their children need not know about yet.

Learning about illness, accident and death, even in the safe setting of the family, inevitably causes anxiety. The parents do not tell the children too much but give as much knowledge as they need to know and can understand.

A person visiting a play group to talk about hospitals will know little or nothing about individual children, the ebb and flow of their inner strengths or their wishes to take in anxiety-making knowledge. The play group leader is unlikely to know about them in detail either, and would be unlikely to anticipate the impact of a talk on any one of the following four children:

A) Mary, aged four years, has been ill a great deal and has already been to hospital twice, at six months and at eighteen months of age. She does not talk about hospitals and may not remember the last stay. But as a result of illness and the hospital experiences she is more vulnerable to stress than other children in her play group. She gets worried when routines are changed or a strange person comes to the group. A visitor coming to talk about hospitals could not know this. Talk about hospitals and illness is likely to worry this child by reviving forgotten or repressed memories, then leave her to cope with the memories unaided.

B) Peter, age three years nine months, had an ear operation at two and a half years of age. The experience was upsetting and his mother was not with him. Since then he has been especially anxious about ambulances and about any cut or bruise to his body. He has more minor accidents than most children. Peter was difficult to settle into the play group, stopping and starting twice before he eventually settled three months ago.

How would Peter react to a talk about hospitals? He has been through an ear operation and now he would be told of other things that might happen to him. Because of the emotional impact of such a talk, he may not listen properly; so to his basic anxiety might be added confusion and further threat. Group "preparation" could add to his problems.

C) Susan, aged four-and-a-half years, had difficulty in adjusting to play group. She started late but is now making efforts to be big and grown up. Everyone, especially the mother who is pregnant, is relieved that Susan is settled in play group before the birth of the next baby which will take place in hospital.

The mother is in the process of preparing Susan for the new baby, and for herself being away in hospital. If Susan's play group is told about hospitals, this already insecure girl could muddle who is going to hospital, she or the mother. It could unsettle her in the play group and thereby add to the family's problems.

(D) Three year old Stephen is going into hospital shortly to have an abdominal investigation and perhaps an operation. His parents are about to tell him; they have not yet told the play group leader.

If the children in his play group get a talk about hospital, Stephen's parents may be forced to tell him about the impending hospital admission before they or he are ready. If this happens, it is clear that Stephen and his parents would not have been helped.

The threat of an operation on their child will awaken anxieties in the parents and will affect the way in which they prepare Stephen. It may be thought that the parents should have told the child sooner, or that a visitor to the play group would introduce the subject better because parents get anxious. But families differ in the ways they cope with such situations. Some may need help, while others do not. These differences should be respected.

What of those children in a play group who have not been patients in hospital, who are not especially disturbed, who have the usual smattering of knowledge about hospitals and who play the usual "doctor and nurse" games? Some of these children will not listen to the talk about hospitals, others will not remember what is said. They may not be affected one way or another.

Others will listen to part of what is said. These are the children whose eyes glaze over at story time, and whose thoughts wander off. These children still live a lot of time in their own world, and join adults in theirs only fleetingly and not to order. They will go home with a very confused understanding of what they have been told about hospitals.

Some will sit rooted to the spot, seemingly fascinated by what they are told. The NAWCH Project Report on Preparing Children for Hospital refers with satisfaction to the children being "fascinated," as if this confirmed the value of what they are being told about hospitals. (3) But this assumption has to be questioned. Children can be fascinated by many a frightening thing which does them no good at all. For example, a child will sit fascinated by a frightening television program until a parent turns it off. Then the child rushes about frantically or sits immobilized, anxiously sucking his thumb.

Play group children can be looked at in another way. There are considerable differences between them in their levels of language, comprehension, memory structure, and concentration. Some will not be able to differentiate between "if" and "when." For example, one child was reported as asking after a hospital talk, "Can I take my Teddy?" He had probably understood that he was going to hospital.

The under-fives are living through a period of fast

psychological growth and they are from time to time troubled by fantasies, anxieties and conflicts. Families know that, without warning, children's moods change. They may become tense, go off their food, wet the bed, or become aggressive or anxious for some days or weeks.

Parents do not always know why and do not have to know why. They tolerate the inexplicable behavior, they support, comfort and take their children to the doctor. Usually after a few days or weeks the children return to an even keel. They have worked through some troublesome feelings -- some aspect of psychological growth.

In any group there will be children who are working through something that is troubling them. To be told about hospital with its threat of illness, hurt and leaving home will add further anxieties to those they are already coping with in the course of normal development. This can only be disturbing to these children and their families.

When group talks are illustrated with medical instruments and books the emotional impact will be greatly increased. Children can shut their ears to some extent to protect themselves from what they do not want to hear. But visual material impresses more and is less easy to forget.

Group visits to hospital carry a further danger that the children see not only the planned exhibit but unplanned ones as well, which could confuse and frighten.

The examples in this paper have been of play group children but much that has been said relates also to the five-to seven-year-olds. These infant school children, too, need protection from educational experiments...for experiments they are.

Studies are lacking on the emotional effect of group instruction or group hospital visits upon young children who do not become patients. There is no evidence that young children who go into hospital a month or six months after a group session have been helped by the "preparation." If children go to hospital how much will be accurately remembered of the "preparation?" And how relevant to the actual experiences will be the information that is retained?

It may be that adequate studies are impossible because of the great number of variables, their subtlety and complexity.

THE AIM OF PREPARATION It should not be the aim of preparation to make children submit without protest or anxiety to hospital admission or procedures. Submissiveness is not the measure of successful preparation. Anxiety and protest are often appropriate. As Anna Freud said, "When the body submits, the mind retreats." (4)

The true aim of preparation is to prevent children's being overwhelmed by anxiety, so that in the longer term they can assimilate the experiences and not be damaged by them. Allowing children to express feelings of anger and sadness, and to play and talk afterwards, are the safest and most effective ways of helping them to cope. These carry no risks and are always helpful. Appropriate books and play materials can aid "working through" the experiences of hospital and the feelings about it.

When young children do go to hospital they need to have their parents to stay, to explain, to support and to comfort. If a parent is not there someone is needed who will take on these functions, ideally a substitute-mother who will stay around the clock. A specially assigned nurse or play person who attends with some consistency can help to a degree. (3, 4, 5, 6, 7)

In addition, preparing children is much more than the giving of information. It is to understand and respond to children's individual reactions to such preparation, and that means knowing children's histories.

Adults are made anxious by the thought of young children going to hospital. But in contemplating the possibility it is important that we bear the anxiety within ourselves--as parents, nurses, play group leaders, play specialists--instead of passing it on to children who are too immature to bear that anxiety.

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Parents are the Best Preparers of Young Children

by Susan Harvey, Cert. Ed. Dip. N.F.F.

Formerly, Tutor, Hospital Play Specialist Course
Southwark College
London, England

Parents are in the unique position of knowing their children's anxieties and recent family illnesses or bereavements. They have looked after their children through minor illnesses, accidents and clinic visits. They have brought their children to the hospital to visit friends, relatives or a mother with a new baby. Their children will have seen and heard the ambulance, seen hospitals with doctors and nurses at work or their pictures on television or in the newspapers. Their children may have asked lots of questions about all this so that they learn about the hospital scene as part of everyday experience.

Strangers bringing information about the hospital could not

know this information about the children they talk to in groups. A hint of separation from home and family, of painful experience, of bodily interference can give rise to anxiety of undesirable intensity.

Young children frequently deal with misunderstandings, anxieties and upsurges of fantasy. Their use and understanding of language is limited. They have a limited concept of time and cannot comprehend either distant past or extended future events. Experience of life and its vivid meaning depends largely upon personality and on individual experience as it occurs. Children easily become confused by facts taken out of the context of their daily lives.

There seems to be no reason, therefore, to prepare young children who are unlikely to be admitted to hospital, until they are old enough to cope with such information. There should instead always be opportunities for children to play out their feelings about any experience that interests or troubles them, without fear of ridicule or criticism. As Erik Erikson says, "For to 'play it out' is the most natural self-healing measure childhood affords." (1)

This does not necessarily mean the use of elaborate play materials. Children will make-do with all the gear lying around at their disposal. If, for example, they are given a hypodermic syringe , it is just as likely to be used as a water squirt as for its intended purpose.

This is not to say that it is not helpful for children to handle such things. It does relieve their fears to know that a stethoscope does not bite or sting and is a kind of telephone or listening machine. But frequently a lolly stick is used for a syringe, and monsters, giants and witches take the places of parents, doctors or nurses who have hurt or angered the children.

A selection of adaptable play materials should always be available at home or in preschools so that children can use play, as they always have, on their terms and in their own ways.

If parents are unable to respond to their children's questions and growing need for information, then responses could be given by those people most closely involved with the children's upbringing. These might be relatives, friends or permanent preschool staff, but not strangers. Answers and explanations should be truthful and given in simple ways that children can understand. Professionals or expert outsiders can help by offering advice to parents, preschool staff and teachers who would welcome information about how best to discuss these anxiety-provoking subjects with young children.

However carefully parents or staff prepare young children for a specific event, however, this cannot prevent pain, distress and anger nor wipe out fears and fantasies. Going into hospital is a painful experience, and adults who want to help children cope with anxiety may see "preparation" of healthy children as a good way to do this. Unless carefully done, it can be an easy way to soothe adult anxieties at the expense of the children.

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Problems in Preparing Young Children for Unplanned Hospital Admissions

by Juliet Hopkins, M.A.
Principal Child Psychotherapist
Tavistock Child Guidance Training Centre
London, England

It is of prime importance for the mental health of young children to protect them from the distress and ensuing disturbance liable to result from hospitalization. (1) It is known that the continuous presence of the mother during hospitalization can protect very young children from post-hospital disturbance. (2) And it is also known that slightly older children benefit from psychological preparation for planned medical and surgical procedures. (e.g. 3, 4) Preparation can help children to be more cooperative in hospital, hasten their physical recovery and reduce the incidence of their subsequent emotional disturbance.

The value of preparation for planned procedures has apparently led to the hope that all healthy children might be immunized against the shock of unplanned hospital admission by educating them about hospital in advance. It is this hope which accounts for the present enthusiasm for introducing education about hospital into nursery schools and play groups. However, this venture is misguided.

Preparation is helpful in two ways: by reducing some anxieties and raising others. Being prepared by an adult reassures children that what is going to happen is not too terrible to be talked about. It tells them that procedures are planned and intended to be helpful, that adults are in control. Good preparation not only gives children confidence in the benevolent intentions of adults, it also gives them a sense of their own mastery and control through being able to predict what will happen. In these ways some anxieties are reduced.

However, to be effective, preparation must also raise other anxieties. It has to set in train the "work of worrying." (5) Children need to anticipate imaginatively some of the nasty things that may happen to them. Obviously this anticipation must differ according to the danger situation to be faced. Imaginative anticipation protects the child from sudden shock and disillusionment and from the sense of betrayal and panic which may occur when horrid events happen unexpectedly. Children should be anxious about unpleasant procedures when these are imminent. This is an important aspect of preparation.

Can these ideas be applied to the preparation of healthy young children who may never go to hospital? Is there any way we can reassure them about the benefits of hospitalization without worrying them about nasty events they may never have to face?

It seems that if we try to educate young children about hospital without worrying them we may fall into the trap of painting too rosey a picture. For example, Patrick learned about hospital in his playgroup when he was four-and-a-half-years-old. When he came home he begged his mother to take him to hospital because the ride in the ambulance would be "so exciting, and there are toys to play with all day and all night."

We certainly do not want to deceive young children about hospital, but do we really want to increase their anxiety about illness and injury and its treatment? Is it helpful to arouse anticipatory anxiety about events which may never happen?

There are two reasons why we should not arouse young children's anxieties about hospital unnecessarily. Firstly, young children are already anxious enough. Secondly, they are so dominated by fantasy that we cannot control what interpretation they will make of our explanations, unless these are very carefully given on an individual basis. We are liable to arouse more acute anxieties than we intended, or we may simply create confusion. Young children already experience intense anxieties as a part of their normal development. One pediatric survey of three-year-olds found that a quarter of them suffered from behavior problems symptomatic of anxiety, such as food fads, sleep disturbance and temper tantrums. (6)

During the preschool period children are struggling to master their anxieties about existence as separate people, about separation, about bodily integrity and the control of bodily functions, about hate and jealousy of the people they love. With such a colossal developmental agenda it is not surprising that many children develop symptoms of stress.

It is also well known that young children have intensely vivid imaginations. It can be hard for them to distinguish

fantasy from reality so that, for example, they may be terrified by television programs or believe that dreams are real. Here are three examples of how young children's fantasies can distort reality:

A) Mary was nearly four years old when someone came to tell her play group about hospital. After lunch that day she gathered together all her favorite possessions and asked her mother to pack them ready for hospital. In the discussion that followed mother realized that Mary was hoping to join her father who had packed his case and gone abroad on a business trip a month before. It seems that Mary's fantasies about joining her father were so strong that as soon as she had heard mention of what to pack for hospital, she had confused the talk about hospital with the hope of rejoining her father, who worked for a pharmaceutical company and often spoke of hospitals.

B) Sylvia was also four years old when her mother attempted to prepare her for a tonsillectomy by reading a children's book designed for this purpose. That night Sylvia refused to lie down and go to sleep and the next night she refused again. Eventually mother discovered that Sylvia was afraid to go to sleep because the book about hospital mentioned how a child was put to sleep for an operation. This family had had a favorite dog "put to sleep" a year before.

C) Sally, a three-year-old girl who was visiting her brother in hospital, started to scream and cry at the sight of an unknown boy in an oxygen tent. She had thought the boy had put a plastic bag over his head and would suffocate.

These three children were all carried away by their fantasies on issues that were highly emotionally charged as, inevitably, is the whole topic of bodies and illness and hospitals. The examples illustrate that parents are the people most in touch

with the ways in which a child is likely to distort information and so they are best placed to sort out confusions. It is very hard to do this in a group.

For example, in one play group at which a talk was given about hospitals, and a box of hospital equipment and a dressing-up kit were provided, everything seemed to go well until discussion time. The following comments were then made by three four-year-olds:

"Doctors didn't make my granny better. She died in the hospital."

"My baby died too." (a reference to a miscarriage)

"When I was in hospital they locked my mummy up so she couldn't see me."

Even the most tactful group leader cannot deal adequately in the play group setting with individual problems like these and with their effect on the group.

In conclusion, I think that attempts to prepare groups of healthy preschool children for the unlikely event of their admission to hospital are a misdirection of skilled time and effort. Our energies would be better spent improving the preparation of parents and professionals to ensure that all very young children in hospital will have the company, comfort and support of a reliable adult.

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Touring Hospitals: Not for Young Children

by Carole B. Klein, M.Ed.
Director, Child Life Program
Rainbow Babies & Childrens Hospital
Cleveland, Ohio

Until a few years ago young children were not permitted to visit hospitals unless they were patients. Now the pendulum has swung abruptly to permit children to visit hospitals openly. This openness, based upon good intentions of teachers and parents has often been indiscriminate, with little awareness of its effect upon children. Among the areas to be opened up has been visiting of hospitals by groups of young children.

Rainbow Babies and Childrens Hospital is the primary pediatric center in Northeast Ohio so it became the major hospital in the area for preschool and elementary age groups to visit. We have, therefore, had ample opportunity to observe

visiting children. Our observations and conclusions have led to a change in hospital policy.

One of the behaviors we observed in the visiting preschool children was a great deal of out-of-control and anxious behavior. When we suggested that, weather permitting, the children go to our outdoor play area halfway through a visit, the teachers had great difficulty in gathering the group togeher again to resume the tour after the play period. The children did not want to come back into the building.

One young boy, clinging to the railing in the elevator, pleaded to be left there until the visit was over, saying "I'll just wait here, please."

Child life workers from several hospitals in the area meet twice a month with a psychoanalyst, Mrs. Erna Furman, of the Cleveland Center for Research in Child Development, for consultations concerning our work. It was at one of our meetings that we began to present our observations about the visiting of preschool groups.

As we examined our experiences with "educational" tours we became increasingly aware that our apprehension about them was well-founded. We could never protect the visitors from the elevator door's opening on a grossly disfigured child nor could we predict the cries of a child in pain or the view through a half-opened door. The young visitor could not know, seeing a child patient alone, if the mother was nearby or had abandoned the child, the greatest fear of children this age.

As Mrs. Furman later wrote (1), "Child life workers found that the children were often so frightened and overwhelmed by what they were exposed to that they could not seem to learn from it or gain reassurance. At first an attempt was made to select

and structure better what would be shown and told. No matter how the child life workers tried, however, something always happened that was not part of the planned tour. Instead of focusing on all the attractive toys in the hospital playroom, the children's eyes remained riveted on a little patient with leg casts in a wheelchair; just walking along the corridor, half-open doors revealed glimpses of emaciated or bandaged-up youngsters or of beds by strange apparatus; even from behind closed doors occasional moans, cries or protests could be heard. These perceptions, usually unheeded by the accompanying adults, proved invariably more impressive than the scheduled items. In truth, it is impossible to enter a hospital without experiencing encounters with illness and equipment that shock and bewilder the unaccustomed adult. The impact on young children is all the greater, beyond their scope of intellectual and emotional mastery, even if an attempt were made to explain it all. Since, however, the preschoolers sense that they are not meant to notice these 'incidental' experiences, they often do not refer to them or question them and are condemned to keep the resulting inner turmoil a guilty secret."

Not only were the tours not in the best interests of the visitors but the hospitalized children also did not welcome the scrutiny and the overheard remarks of the frightened visitors. Convinced that both groups of children needed to be protected, we cancelled all tours.

Instead, a program was created that volunteers could take into the preschools. There, in the familiar safe environment of the school, the children could see a film tape, listen through a stethoscope, and handle a hypodermic syringe. Each child could explore to the extent he or she chose, protected from being overwhelmed. This, then, became a truly educational experience.

We worked hard to make our decision about tours clear to the

members of the hospital board. Hospital administrators, public relations departments, and board members often tend to look at tours as good publicity for the hospital. They bring a lot of pressure to bear for instituting such tours.

Preschool teachers can also be helped to understand the potential hazard of group tours for young children. We point out that we cannot predict what perceptions individual children will have. In addition, we remind them to urge parents whose children will be hospitalized to arrange for a preadmission tour and to plan on staying overnight with their young children.

There is a great deal of work to be done with young children admitted to hospitals. Parents need to plan individualized preadmission visits for their children's elective admissions. Well children, however, need to be protected from the unnecessary trauma of group tours through hospitals.

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Preparation Programs for Young Healthy Children

by Mary Evans Robinson, Ph.D.
Pediatric Psychologist and Director, Child Life Department
Children's Hospital National Medical Center
Washington, DC

Since 1972 Children's Hospital National Medical Center in Washington, DC has been providing a special puppet show and tour for children from three to twelve years of age who are planned admissions to the hospital. The goals of the program are to familiarize the children with the hospital, prepare them for what they will experience there, acknowledge the legitimacy of their feelings, and give their families the opportunity to ask questions.

Since 1974 the hospital has also been sending specially trained volunteers to meet with groups of children in preschool settings (1, 2). This program is not designed to prepare children for actual hospitalization, but seeks to engender positive feelings about hospitals and health care. It tries to help children understand the hospital is a special place where

they can be cared for by people who understand and accept their feelings.

Children who are three- and four-years-of-age are already aware of and concerned about hospitals and medical procedures. Well-cared-for children have already had a great many visits to doctor's offices and, having had their immunizations, have had several shots. If they have not had direct experiences with hospitals they have had indirect experiences if friends, neighbors or members of their families have been hospitalized. They also have been exposed to television and, in the United States at least, television scriptwriters show a preoccupation with hospitals and often portray them in a frightening, unrealistic way.

I share the concerns about bringing preschoolers to the hospital. At one time we had school tours of our hospital but found we could not control what the children saw. We were also concerned that children already in the hospital were being put on display for their peers. Additionally, we reached relatively few children at great inconvenience to the hospital.

Instead, our present preschool visiting program involves a presentation which consists of three parts: Reading a story and showing pictures to impart our message, demonstrating hospital equipment, and encouraging children to use this equipment to "play hospital."

We feel the program has been extremely successful. We have more requests than we can accomodate. Teachers repeatedly comment that the preschool visit has been one of the more successful class activities. They also report that it engenders more discussion than any other activity. Preschoolers' concerns about their bodies, medical procedures and hospitals are already there. We do not create them with the program.

It is important to remember why preparation programs were started in the first place. They were a response to the severe stress and poor recovery rate which those of us working in hospitals saw in the unprepared child.

There was a time when children were brought to the hospital without being told anything or after being told things which were, frankly, lies; for example "You are going to a birthday party," or "You are going to visit a friend." The natural extension of preparation programs is to reach children before they need hospitalization, to prepare them in the preschools.

It has been suggested that sensitive parents, aware of their children's needs, could prepare their children when it is necessary. However, very few parents, even those armed with information from physicians and other hospital staff feel confident to do this job alone, and they are generally delighted that the hospital is willing to provide a preparation program. Even when parents have done the preparation and have done it well it is reassuring to the children to have the information confirmed by the hospital staff.

Certainly, whenever possible, preparation should be done in the parents' presence so the parents will know what the children have been told and will be able to incorporate it into their own explanations.

All of us who work with hospitalized children are indebted to the Robertsons for their pioneering work which had a major impact on hospital visiting policies. While I take issue with their opposition to preparation programs, we are again indebted to them for reminding us that we must evaluate carefully the impact that such programs are having on our children.

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Current Preparation Research and Practice in One Community

by Patricia L. Mather, PhD.

Director, Child Life Specialist Program
Utica College of Syracuse University
Utica, New York

There has been a major trend toward the preparation of children for hospitalization in the United States. Many hospitals offer orientation programs for healthy community children as a part of their preparation programming. The hospital tour, for example, is one of a number of methods being used in these preparation programs. The variety of techniques from which to choose poses a dilemma in that some may be more appropriate for certain age groups than others.

When choosing a preparation program consideration must be given to children's developmental levels, needs and previous health experiences. This is especially true for children under

seven years of age whose cognitive immaturity and emotional sensitivity to stress can affect their response to preparation.

In the Utica community several models of preparation for healthy children have been utilized, and some of them have been tested. I will describe the rationale, content and apparent success of these programs, which could be used either instead of or prior to hospital tours.

Hospital preparation programs in the Utica community serve elementary school children who are six years of age to eleven years of age. They come to a hospital meeting room to experience a skit, puppet show, story hour or slides about the hospital. Although the children are in the hospital building, these events are not followed by a tour. Instead, small group play experiences are encouraged, using real and play medical equipment such as stethescopes, blood pressure cuffs, otoscopes, play needles, hospital gowns and masks. Adults guide the play groups by emphasizing information, encouraging children in their play and answering the children's questions. These adults are usually college students trained in child development and child life through the Utica College Child Life Specialist Program.

Two classrooms of preschoolers, from three through five years of age, have participated in the orientation programs in the hospitals. Community preschools have usually preferred to have story hours with guided play activities led by college students in the preschool. Several preschools also participated in preparation research in which children saw a puppet show about the hospital and then engaged in guided play.

All of these activities seem to be meeting the needs of our community children and educators. There are various types of evidence indicating this:

Teacher Reports: Feedback from preschool and elementary schoolteachers has been positive. In particular, teachers have noted the benefits of allowing the children to handle and play with equipment and puppets under the appropriate guidance of an adult who is sensitive to the cognitive and emotional needs of the age group. Teachers have sent children's pictures and their "thank you" notes to support their claims.

Parent Reactions: Parents have not voiced complaints about the programming their children have received nor about the children's reactions to it. One parent, however, reported to me that her preschooler came home asking if he was going to the hospital. She was able to explain that he was not going there and then discuss with him what he had learned from the program. She felt that it had been a good learning experience for him.

Research Findings: Parents permitted their children to participate in a research project on preparation in several preschool classrooms. (1, 2, 3) The research involved pre- and post-testing children about the use of various medical objects used in a puppet show and guided play experiences. Thirty-nine children were present on three separate days for the pre-testing, orientation program for the classes, and post-testing. They were asked to show what was done with a hospital bracelet, thermometer, stethescope, blood pressure cuff, otoscope, tongue depressor, play needle, and anesthesia mask during the testing.

Analyses of the data revealed that children's knowledge about the medical objects increased significantly ($z=4.43$, $p<.0001$), particularly for children from lower social class backgrounds ($T=.29$, $p<.019$). Children tended to learn the most about objects that were novel to them. Information from questionnaires completed by parents indicated that children who were rated by their parents as less anxious in new situations did better on the pre-test, but there was no relationship between anxiety and

post-test performance or amount of learning. Children with prior hospital experiences knew more before the program and acquired additional knowledge from it.

Anecdotal evidence indicated that individual children with fears from previous hospitalizations responded positively to the program. One young boy who cried and refused to be pre-tested, for example, was able to handle equipment during post-testing and demonstrate its use.

CONCLUSION Evidence supports the conclusion that young children can learn from a hospital preparation program. Preschoolers profited from programming that was done in the familiar environment of their classroom. This programming had several characteristics that made it appropriate for the abilities and needs of preschoolers:

A) It employed puppetry which utilized the imaginative and magical thinking of the children while providing them with information.

B) Topics of concern, such as possible separation from parents, and emotional reactions, such as fear of needles, were addressed. Information to clarify misconceptions and provide solutions and coping mechanisms were illustrated by the puppets.

C) Language appropriate to the skills of preschool children was used and medical terms were explained in this language.

D) The 8-10 minute puppet show was the appropriate length for the attention span of children this age.

E) Since children need to touch and play with objects to learn about them, opportunities to handle puppets and equipment were given to the children to encourage modeling and concept

development.

F) Adults trained in normal child development and children's reactions to hospitalization presented the puppet show and guided the play experiences.

G) Parents were informed of the program prior to its presentation so that they would be able to support and supplement what was done. (However, structured information and suggestions were not given to parents. This should be added to community programming of this nature.)

H) Preschool teachers prepared children for the program before it began. (Since teachers may have varied in how they did this, more contact with teachers to decide how this will be done would be helpful.)

The preschool children in our community programs seem to be learning from preparation programs in the classroom designed especially for their developmental level. These programs do not involve hospital tours, but they offer alternatives to them within the classroom, or the means for preparing a child for a hospital tour.

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Preparing Nonpatient Children for Hospitalization

by Carol Hardgrove-Aldrich, M.A.
Clinical Professor, School of Nursing
University of California, San Francisco and
Director, Family Futures
San Mateo, California

More than two million children under the age of six are hospitalized annually in the United States. (1) Almost all children have some sort of hospital encounter in hospitals, clinics or emergency rooms. For this reason it is important to prepare children for hospitalization even though they are not now and hope never to be patients in a hospital.

Age-appropriate, non-threatening preparation offered in children's familiar environment can increase a sense of security in the institutions that support the family and the community. Children can learn to see the doctor or nurse who visits their

school as a real life, caring, interested person.

In return, doctors and nurses who may not have had many experiences with well children can learn how children think and feel. They can become more sensitive to children's perceptions of care, and can learn to communicate more effectively in their encounters with their young patients in their practices.

A third reason for preparation is to counteract the myths that children create and exchange. For example, at a recent children's health fair the nurse-organizer of the event greeted incoming groups of kindergarteners with, "Who can tell me what hospitals are for?" The first answer was, "To kill people." Quickly the nurse moved on to the next raised hand. This child answered, "So the big people will have somebody to work on."

It is no secret that hospitals are seen this way by people far older and wiser than these children. Television soap operas featuring hospital dramas are watched by children, too. It is clearly important to counter this negative image and to foster an awareness that the health system exists to help people.

Children have equally distorted ideas of other community services: Fire engines, some children think, set fires. Many children are terrified of sirens, not so much because of their noise but because they are worried that their house will be the next target of the fire engine's hunt for a place to burn. Police officers, some children (and many adults) think, only search for people to put in jail; they do not consider that the police also serve a protective role.

For these reasons some kind of preparation is needed. The question is, what kind and where should it take place?

If we want children to believe they are among friends when

they come for health care we must start preparing them early--in the home, if possible, and through encounters with children and parents in well-child care, in clinics, preschools, day care centers and wherever children are cared for in groups.

Preparation for the possibility of hospitalization is quite different from preparation for the inevitability of hospitalization. Both are important, but they call for different techniques and experiences. The goal of each is the enhancement of children's (and families') trust in the system and the professionals encountered.

As in all teaching and learning we must know our learner's ability to comprehend what we are attempting to teach. We must gear our approach to the children's developmental and cognitive levels.

In order to do this we need teachers and guides who can speak "childese," which is different from baby talk or whimsy; and teachers who can read nonverbal as well as verbal cues so as to assess the children's comprehension.

Presenters need skills in communicating with children at their developmental levels, and skills in working together with parents so that the teachings will be reinforced at home. Presenters need to welcome interruptions that help children participate in the discussion, need to offer multi-sensory experiences that dramatize the presentation and encourage role play and hands-on play with medical equipment. They need to provide materials for stories and dramatic play that will follow the demonstration.

For children who do not face hospitalization themselves there are more effective, less expensive, simpler ways of developing positive attitudes toward health care and providers than the

in-hospital tour. A group of children touring a hospital must use a large portion of their energy and attention to orient themselves to the unfamiliar environment. This distracts them from seeing and hearing what the guides are telling and showing, thereby losing much of the effectiveness of the tour and threatening children with a new batch of fears, distortions and misconceptions. In addition, patients may find it unpleasant to be treated as objects on display for the edification of the touring children.

Instead, bringing information to groups on their own turf gives them more of a sense of safety and control. It is easier for them to listen and learn, easier for them to bring out their own questions, concerns, misconceptions and past experiences.

In the preschool, nurses and doctors who visit can encourage children's learning more about health care. The teacher who knows the children can interpret as needed or direct the visitor's remarks to the children the teacher knows need special help. Children can contribute their own ideas which can then be modified, if necessary, with correct information. The children are intrigued as the visitor settles in the center of the story circle, opens the black bag, and holds aloft the mysterious clothes and equipment for their responses.

Demonstrations using stuffed toys or dolls can illuminate procedures. Frightening medical equipment can be handled and demonstrated in this non-stressful atmosphere. Children who are nervous about the presentation can watch from the safety of a teacher's or a parent's lap. Play that follows such an informal time can be revealing to the visiting professional as well as therapeutic to the children. Repeat visits are even more informative and welcome.

Children can also learn and play about hospital experiences

at home. It is certainly helpful and important for parents to prepare their own children. But preparation is too important to leave to chance. Some parents cannot offer articulate, accurate information unless and until someone has helped them. If parents tell their children nothing about health care, children may get the message that the topic is too awful to be discussed. As with the subject of sex, no mention still transmits an attitude.

There are some fine books for parents to read with their children that hold interest and help children understand at their particular level. (See books listed at the end of this publication.)

When selecting books about their bodies and about health care for preschoolers and young schoolage children, factual books are interesting enough. At this age children are eager to learn about the world and would usually prefer to hear about boys and girls like themselves who have had experiences with the hospital than about monkeys, mice and bunnies who have surgery. It is not necessary to make this information "cute" in order to gain the children's attention.

Parents can also talk with their children about good things that happened in the hospital when the children were born and help their children see the hospital as one more example of the community's concern for their well-being.

Well-prepared children recover faster, cooperate better, and are less likely to have negative sequelae. It saves time for the health care professionals who treat children, as well as saving anguish for the children, for them to have preparation that is appropriate to their situation.

Parents report that when an unexpected hospitalization occurred following such preparation at school the experience was

easier for both. Parents had learned how to behave supportively, and the children showed more interest and trust. Staff saved time and were able to examine and treat the children more easily.

We have been discussing preparation of the nonpatient child who is facing the possibility of eventual hospitalization. The case is different for the child confronted with the inevitability of hospitalization either for self or for a close relative or friend.

While I am opposed to hospital tours for nonpatient children I am very much in favor of individualized tours for children and families facing immediate hospitalization. Even then, such tours are best limited to what children will actually see, hear, smell and experience. It is especially then that children should have someone to turn to with questions and remarks.

Smelling the smells, hearing the noises, pushing the buttons, shaking hands with the staff can give children a true sense of what is happening. Children learn through manipulation, through multi-sensory experiences. Picture books and slide shows have their place, but they do not do the job entirely. Having the actual experience helps children gain a sense of mastery, provided that there is an understanding, knowledgeable and observant adult present to pose and to answer questions. In addition to showing children the places where patients are cared for, if time allows, they can visit the kitchen, laboratory, laundry and gift shop.

When a preparation program is to take place using the hospital or clinic as its locus, such orientation is best undertaken in a non-threatening environment, not a clinical area.

Even this direct approach does little more than open the

subject for discussion and let the children know that they can count on the adults for the truth about what is to take place. Only after the fact do the event and the explanation fit together for young children.

The teacher or hospital volunteers who want to have schoolage children visit the hospital for educational reasons should precede the tour by the in-school visit and play period. And, rather than parading the groups through the wards, a mock-up room should be used as the site for preparation.

There should also be enough tour guides to insure that children's questions can be heard and answered. It does little good to give a speech to a group of children with which one is not acquainted and then ask, "Are there any questions?" Even adults have difficulty framing their concerns in response.

Instead a well-trained group of adults should be able to see, through body posture, facial expression and the spoken word, children's anxiety or comprehension.

As a former preschool teacher who took children on many excursions to airports, firehouses, pet shops and dentists' offices I know how many surprises a teacher can get, not only from the children but also from the adult guides who have volunteered to explain to the children. Over the years I learned to interview them prior to introducing them to their child audience so that I could give them an idea of what was appropriate to say to children of that age. Without that precaution we encountered police officers who, thinking the children would appreciate the joke, threatened the youngsters with jail; fire fighters who went into gruesome detail about the outcome of playing with matches; and airport guides who went into expansive detail over the engineering of the 707 (while the children were more interested in the plight of the ladybug

swimming in a puddle on the observation roof).

No matter how well and comfortably the tour is conducted or the presenter speaks, children need ample opportunity to discuss and play out the experience upon returning to the familiar school, not once but many times.

Whatever devices are used in preparation parents should always be offered information that enables them to give adequate facts to their children at home. A program presented by people with a strong background in child development can help families to prepare children at home, thus aiding the transfer of children's trust in parents to trust in the caregiving professionals.

There are a number of ways in which to prepare: puppet shows, slide shows, movies, books, dolls, and medical equipment for role play.

Whether puppets are used or not in programs for nonpatient children they should only be an adjunct to the ongoing comfortable involving demonstrations mentioned earlier. Puppets can be a valuable tool but too often they become a gimmick operated by volunteers who may or may not be able to communicate with children. They may or may not continue doggedly through their well-rehearsed puppet show regardless of the children's disinterest or mild anxiety.

A puppet show presented by a stranger to a group of unknown children may be right on target with some of the children, increase the fears and anxieties of another segment and be incomprehensible to others. Some children may be so interested in the puppets that they miss the message entirely.

My objection is less to the puppets, however, than to the

puppeteers. Successful puppeteers know both their subject and the audience. Fred Rogers, of the television show, "Mister Roger's Neighborhood," for example, does a fine job because his understanding of children and principles of child development augments his skill as a puppeteer.

In summary: Preparation is not a one-time thing. It is a series of communications that begin at home and take place whether the responsible adult intends the communication or not. Adults who want to foster positive attitudes toward health care need to get to families early , making suggestions to parents and monitoring their own behavior.

Each medical encounter should afford the child and family an explanation and adjustment opportunity to that specific experience.

The goal of the program for nonpatient children is to open the subject for discussion, to detonate some of the anxieties that accompany the sight of medical equipment, to create or enhance children's feelings of security as part of a community that cares about them, and to see physicians, nurses, and dentists as people who have special interest and skill in helping children.

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Prevention in Practice — Practice in Prevention

by Graham Martin, M.B., B.S., M.R.C.G.P., F.R.A.N.Z.C.P.,
D.P.M., Dip. Fam. Ther., Cert. Accr. C. Psych.

Child and Family Psychiatrist in Private Practice
North Adelaide, South Australia, Australia

As a psychiatrist, a student of the mind, a hopeful trying to unravel psychological complexities, it has always fascinated me what events in our lives prove influential--to our development, to our later years and perhaps even to future generations. For instance, at the age of twelve, if the reader will pardon my discussing it, I developed an ingrowing toenail and whilst my family and I tried all sorts of measures to stop matters getting worse, worse they did become. Eventually, over a period of weeks, I was left with a painful reddened big left toe with its nail embedded in overgrown flesh. In some desperation we went to our local doctor and, in his wisdom, he decided he would have to operate and remove part of the toenail to let the rest heal. I

watched fascinated as he pressed the hypodermic needle down the sides of my precious big toe, and felt with awe the numbness steal from the tip to the middle joint. A few minutes later, I watched with equal fascination while he, quite painlessly, removed the toenail.

I know that it was that somewhat bizarre process that decided me, at age twelve, to become a doctor. The man knew just where to place that injection, just which nerves needed to be anesthetized to deaden the feeling. I could and would learn such wisdom. The impression on my young mind, not to mention my toe, was indelible.

At about the same time in my life I read a science fiction story. Whilst I cannot remember the title of the book, I can remember part of the story line. There existed a parallel reality to our own, peopled by time lords who retained the ability to go forward and backward and, if necessary, step into our own time and reality. Contrary to most stories regarding time, this story allowed those from the future to meddle in any time zone they wished, knowing that the future might be rewritten. These time lords, aspiring gods, perceived a catastrophic end to our world and decided on a drastic course of action. One of their number travelled backward in time and stepped across into this parallel world. He found a particular young man driving a car through a desert town in America. When the young man stopped to refuel, the time lord loosened the wheel nuts of one of the wheels on the car, and returned to his own land. The young man, having refreshed himself, returned to his car, started the engine and began the journey across the desert to his destination--a far-off university town.

Some miles out of the town he had left, the wheel eventually shook loose from the car and the whole thing skidded to a stop. It took the young man many hours to return by foot to the town

and, during the time he was there, waiting repairs to his car, he met a young girl. As a consequence, the young man never did get to the university town and, as a result, he never signed on at the university. As a direct result of that he failed to hear an eminent physicist talk and therefore did not take on a consuming interest in physics. As a result of that aborted interest the young man never began any researches in physics and, as a direct result of that, he never discovered nuclear fission. The atom bomb was never invented by that young man and our world was saved from its dire consequences.

There is a part of me that wishes wholeheartedly that some benevolent time lord had, in truth, done something of the sort for our world. Alas and alack, it has not happened and we have to live in the shadow of nuclear technology.

There is another part of me that has a fantasy that, as a psychiatrist, I have some similarities to a benevolent time lord. In travelling with my patients into their past, I can sometimes change not the real event, but their perceptions of past events and of the people who enacted those events and, in direct and indirect ways, perceptions of present events and current relationships may change. We all have our fantasies!

I have a patient who developed Anorexia Nervosa at the age of eighteen, some five months after she began to live with her boyfriend and four months after her maternal grandmother died. During her admission to hospital, this patient produced an extensive series of paintings, each one of great significance to her and her stage of therapy. One painting was a memory of her as a five-year-old lying in a hospital bed having had an operation on her neck to remove a tumor. Over the bed hung a heart-shaped strawberry with an arrow through it. Subsequent paintings revived other locked-away memories from that time--hands with dirty fingernails grabbing at her throat;

clothes being taken off against her will; intrusions into her body spaces with hypodermics and other instruments--all quite terrifying to her in their vividness.

In exploring the original painting the girl remembered many feelings of anger at parents who could visit only briefly and intermittently, in part because of hospital ruling and in part because of commitments to her younger brother and sister; distress at the intrusive hospital procedures; joy at the visit of her grandmother who had brought strawberries for her to eat. But my patient could not, or would not, eat and the strawberries were eaten by the nursing staff. The intrusions continued.

It was from this point in her therapy that my patient began to recover. She began to grieve her grandmother's loss, grieve her lost virginity taken somewhat forcibly by the boyfriend, and come to terms with her separaton from her family. It was as though the original experience encapsulated grandmother, being attacked, separation from parents, and not eating; and the memory lay dormant until revitalized by the grandmother's death. The experience of hospital as a five-year-old proved to be an integral part in the development of her Anorexia, though it would be a banal oversimplification to say that, in some way, the hospitalization caused the Anorexia.

TWO CONCLUSIONS I would like to draw two conclusions. The first is that a significant painful set of circumstances in childhood may have serious repercussions later in life, given the right triggering events. The second is that it often takes many hours of painstaking work to travel back in time with patients to unravel past events and put them in perspective, allowing those patients to lead more normal lives.

To put the first point in a more positive light: One small action perpetrated by one individual on another may, with time,

promote major changes in our world. This I believe!

The problem, of course, is how to ensure that such major changes are for the better and not for the worse. Sometimes, dropping a stone in a pond haphazardly can cause such ripples that where weaknesses exist the banks may be washed away. We have to be more careful, caring, precise, and positive-thinking than that. When we begin to consider changes in, for instance, health standards for children in our community we do then have to be very careful, caring, positive, and precise--which brings me to the title of this paper, "Prevention in Practice--Practice in Prevention." What do I mean by this and of what use is it to you? Let me begin in the middle.

In 1972 and 1975 two workshops brought together a mixture of professionals from within the hospital system and concerned parents, under the auspices of the Adelaide Children's Hospital in South Australia. The workshops were attended by over one hundred people, professionals particularly concerned about the emotional (as opposed to the purely physical and medical) needs of sick children, and parents whose experiences with their children in hospital had suggested that the hospital environment could be improved. Out of those two workshops derived two rather unique groups.

The first, centered within the hospital, was a group of professionals with representatives from most disciplines. This group became known as the "human relations workshop committee." The second group consisted of equal numbers of medical professionals and concerned parents and retained the relative freedom of being outside "the system." This second group became the nucleus for a South Australian branch of the Australian Association for the Welfare of Children in Hospital. Many of the aims of both groups were identical, for instance improving the emotional care of younger children, providing play facilities

within the hospital, and promoting live-in facilities for mothers. However, the workshop aimed its educative attempts predominantly within the hospital, whilst AAWCH aimed not only to educate the wider public but also to attempt necessary political change.

I am sure that at that early stage in my own development, I did not realize that children in hospital needed welfare, despite a good basic medical training and despite access to an extensive literature going back to the 1950's. I assumed that children went to hospital for good reason and that expert doctors, nurses and other personnel did their very best to ensure, firstly, that the medical problem was solved or at least ameliorated and, secondly, that the child's stay was as short as possible, and, finally, that the child was well cared for. Of course, all that was happening, but there were problems. Through my growing experience of children being in hospital, particlarly children with long-term problems such as burns or chronic illnesses such as asthma, cystic fibrosis or diabetes, I began to learn that children, particularly young children from ages two to five can become distressed by the "being in hospital." That is, not just the illness effect or a reaction to operation or painful procedures and injections, but a reaction to the strange environment not scaled down to child-size; a reaction to the strange people who, whilst basically caring, are busy, often tired and stressed and have their own lives to lead; a reaction separation from a caring, close, concerned family life, and the younger the children the more crucial this element in particular becomes.

The children I saw as a child psychiatrist in training within the hospital, even in 1975, showed angry reactions to the staff or to the parents who were seen as leaving them in hospital. The longer small children were separated in hospital the more difficulties arose. They became exceedingly distressed and at

times were seen to become quieter, withdrawn and detached from their surroundings, only to erupt into tears again when parents reurned to visit. The children were not upset by the parents or their visit but were reminded of home and their lost attachments and naturally blamed the parents for this loss, with all of the conflict that could arouse.

The problems did not stop there. Some children, perhaps more sensitive or with pre-existing problems or perhaps unable to share their distress more directly, seemed to go backward in their development. They found schoolwork more difficult, could not socialize as well, and sometimes began to have nightmares, wet the bed at night or develop other symptoms of anxiety. Of course, they needed extra help and understanding. If the fears and worries did not resolve in a short time their distressed families sought help in the Department of Psychiatry.

So I began to recognize, as many others had before me, that a problem existed. That is the first point in prevention. You cannot prevent something if you are not aware that it occurs!

PREVENTION IN PRACTICE Prevention is possible at three levels. Clearly, the best way to avoid the hospitalization reaction is to stop placing children in hospital in the first place. This is usually called "primary prevention." But how can we stop illness? Of course some illnesses as yet cannot be stopped. But many hospitalizations for illnesses can be stopped if, for instance, the illnesses are picked up early enough. Further, a large percentage of hospital admissions are a result of accidents. Many of the fractures, abdominal and head injuries, burns and scalds can be prevented if only we begin to think about them in the right way. I know that many caring mothers spend a large part of their days supervising their children in order to prevent accidents, and yet accidents still occur.

There are two other stages of prevention, "secondary" and "tertiary." In terms of the hospital reaction, secondary prevention is aimed at reducing the likelihood of occurence of such distress once the child is in hospital.

Our volunteer group, AAWCH, in a number of ways has been able to help hospitals change throughout Australia but with particular success in South Australia. The suggestions for change have not been pebbles thrown into the pond haphazardly but have demanded that our group of ordinary concerned citizens share and discuss the implications of medical research findings, grasp an understanding of the complex principles involved, liaise with the relevant groups of influence within the hospitals, and lobby effectively at many levels in society. Open visiting, live-in parents, play leaders available on wards with adequately equipped play areas free of medical intrusion, more appropriate hospital design and decoration have all been innovations promoted by AAWCH.

Perhaps the greatest thrust as an organization has been providing educational materials, such as policy documents for government departments, a national journal to cross the interface between parents and hospital staff; coloring, story, and game books for children; specific educative pamphlets available for parents, describing the hospitals and procedures. All of this written material has worked at two levels. It has helped hospitalized children and their parents adapt to the hospital system, which is secondary prevention. It has also helped increase awareness of parents and hospital staff, which is tertiary prevention. They recognize potentially severe hospital reactions and deal with them earlier, thus hospitalization has much less of a long-term effect for many children.

So that is prevention in practice: Seeing that a problem

exists, thinking about it, and working out the many ways to alter the problem, using the three levels of prevention, providing the energy, enthusiasm and pressure for change both from our volunteer groups and the special committees within hospital systems.

PRACTICE IN PREVENTION In 1978 we became aware of some major problems in the literature and education aid we were providing. On the whole they were in written form, and more and more we became aware that people do not read except when they are forced to. Especially we learned that disadvantaged families did not seem even to gain access to our material. Like so many groups before us we were preaching to the converted.

When we reconsidered, several directions emerged:

A) To update the available written material to make it more acceptable both to children and their parents.

B) To make existing material more extensively available.

C) To provide something with a visual impact.

D) To investigate other methods of getting information across to children and their families.

We were particularly keen to make the general community more aware of the possible problems associated with hospitalization and reactions, and wanted to use the climate and financial incentives of the 1979 International Year of the Child to promote our aims. To this end, a week in the middle of 1979 was designated as "Children in Hospital Week" and a number of innovative programs and media exercises ensured that the community was made somewhat more aware. In South Australia 50,000 copies of a coloring-in and games booklet about the

hospital were given out.

As far as the "visual impact" was concerned we felt that, if we could show on film and model how children and their families might behave in hospital, then we might reach those other groups who are probably in greater need of knowledge, at greater risk of illness in the first place, and where financial constraints can make it impossible to attend on a sick child in hospital if there is no apparent known good reason.

With all our discussion, research and learned thought we still did not get it quite right! It takes practice! We made a 27-minute video called "Doctors and Nurses." It was made over two weekends with the help of the Adelaide Children's Hospital/Queen Victoria Hospital medical television unit and with over fifty people giving their time free of charge. The film has been used with great frequency and to good effect in the hospital and with outside groups. For instance, it has been shown at kindergarten parents' meetings and to many professional groups having interests in child care; further, the film has been made part of a twice-weekly tour of the hospital for those children who have admission planned for surgical or medical treatment.

There are a number of problems, however. Some of these problems have only become apparent retrospectively, others became apparent as part of a research project designed around the use of the video film. I will briefly describe the research project and then the problems we have discovered and how these have been dealt with.

We collected over 100 children awaiting short-term admission to hospital for minor surgical procedures, and divided them into three matched groups. To group one we showed our own video film, "Doctors and Nurses," upon their admission to hospital. To the second group we showed a neutral film of the same length but

having no reference to hospital. The third group had a standard admission procedure but were not shown any film at all. Over the period of hospitalization the three groups were in all respects treated the same and were investigated using a number of instruments. Firstly, we asked the parents to fill in a questionnaire on basic demographic information, on their own fears, and on what they perceived as their children's problems and fears. Secondly, we measured state anxiety on a number of parameters: a self report measure of hospital fears; observed anxiety using specific observations, timed sampling, and trained observers; and a physiological measure of state anxiety, the Palmar Sweat Test. Finally, we used a scale which measures whether the child sees himself as in control of his own life or whether he believes that others control his life, the Locus of Control Scale. The investigations were applied at five different points over admission and follow-up one month after discharge from the hospital. Some general conclusions came from the study:

Firstly, we were surprised to note that we could indeed measure anxiety on a number of measures in all of the children even though the admissions to hospital were over such a short period. Secondly, there was some difference, statistically significant, between the three matched groups, the group having been shown the test video having less physiological anxiety immediately post-operative and at follow-up, even though the group who were shown the neutral video reported less anxiety immediately pre-operative. Overall the group who had nothing but the standard admission showed the most anxiety on all measures and this was true at the one month follow-up. The results for the younger age group showed less statistically significant differences between the groups, although on the whole children of ages four- to seven-years-of-age tended to report more anxiety than the eight- to twelve-year-olds. Finally, there was a suggestion that backed up the clinical impression that anxious parents tended to have more anxious children.

Clearly the differences between the younger groups and the older groups are to be expected when I tell you that the young actor who was the subject of our videotape was aged ten years. It is now our understanding that younger children of ages up to seven years find it much harder to model on an older child and, as is well known from the literature, it is the younger age group, particularly from ages two to five who may be at the most risk for hospitalization reactions. We should have known--but then it takes practice!

A further problem is that the film has been used predominantly within the hospital situation and with some voluntary groups. It does not, however, reach those disadvantaged groups I have mentioned. It is not on general release and has not been shown, for instance, over prime time television.

Back to the "think tank." This time our committees came up with a project worthy of the title "prevention." Further, the project was deemed important enough to be funded through a government department. AAWCH (S.A. Inc.) has had produced 1000 "hospital play kits" which consist of a rigid cardboard box containing a stethoscope; some real X-ray photographs; literature for teachers, parents and children; a story and coloring-in booklet; syringes; and patterns for making rag dolls--a doctor, a nurse and a patient. Now we think we've got it! These kits have been distributed to each of the five hundred kindergartens in the state of South Australia, free of charge, and it is hoped that over the years every child between the ages of three-and-a-half-years- and five-years-of-age, disadvantaged or not, will have the opportunity to be taught about hospitals, see some of the instruments, have the story books read to them and play dramatic games with the dolls. They should be able to do this under the guidance of trained kindergarten teachers who have

access to resource people from AAWCH (S.A. Inc.) who can be made available to help with the education program.

A research project has been completed on these hospital play kits which shows that, in the short term, they improve information about, and attitudes toward, the hospital. As yet no long-term study has been carried out to see whether such information and attitude change is sustained over a number of years. Clearly there is a need for such a research project.

Further, aims of such prevention programs are threefold: Not only to educate or to improve the attitude but also to reduce anticipatory worry and anxiety both during hospitalization and in the long-term post-hospitalization. As yet, we do not have information as to whether these hospital play kits will be of assistance in all of these areas. Clearly such research projects deserve to be funded in the long term.

Finally, in view of the learning that we were able to do as a result of the research projects on "Doctors and Nurses" a new video film has been created and completed by the medical television unit at the Adelaide Children's Hospital. The film, "Special People," runs for 21 minutes. It was designed after a long discussion about, and research into, the impact of children's television programs. The film shows three short episodes of hospitalization for different children, and includes a clown and a nationally known children's character both being hospitalized. The film is linked together by a nationally known children's presentor. Members of the hospital and the AAWCH (who also supplied a part of the funding) gave inputs to the designer, Richard Sprod.

Initially, the film may only be made available to hospital groups in a manner similar to its predecessor, but eventually it is our wish to add access to video, or a tape-slide presentation

derived from it, to the package made available to all of the kindergartens in the state. In this way all children, at a crucial stage of their development, will be able to learn the facts about being in hospital; grow as positive an attitude as possible to the hospital, its staff and the procedures; and assimilate the experience visually, auditorily, and through the medium of play. Such an experience could be repeated during the early school years and, if children are then admitted to hospital for whatever reason and however acutely at some later date, they could have similar information re-presented and have the best available secondary prevention of the hospitalization reaction available. Any innovative educational procedure used in the hospital at the time, any structured playing-through of the experience, any explanation by staff will then be an added bonus.

There has been some criticism of such a project, with the suggestion that perhaps such educative procedures simply raise children's anxiety unnecessarily, given that only 50% of children under the age of seven may have any kind of admission to hospital. Our research project on "Doctors and Nurses" does show that the hospital videotape increases anxiety on a number of measures immediately after the film is shown, but it also shows that at the one month follow-up such measures of anxiety are all reduced below the level of the two control groups.

This seems to add weight to the argument that some anxiety is necessary for the working through of an experience, but that if such anxiety-provoking experiences are satisfactorily worked through, then the long-term anxieties are reduced. It is our belief that the preventative package we are trying to develop for the kindergartens of the state of South Australia may well raise anxiety in the short term. Nevertheless, such anxiety will provoke questions and, with the right sort of support, kindergarten teachers will be able to answer the questions and help the children assimilate their multiple impact experience,

providing a firm basis for the future.

I would like to make two additional points. Firstly, there is now evidence accruing that prior knowledge, a positive attitude, a low level of anxiety, and family support have some kind of direct positive effect on the physical healing process. Children recover from anesthesia and operation more quickly and their wounds or infections heal more rapidly. Clearly, our efforts at a community level in South Australia are part of a complex of improvements in health care and must be having some effect at this medical level. For instance, the average number of days spent in hospital by children in South Australia has continued to decrease over the last ten years.

Secondly, we believe that it is as important for parents of kindergarten children to have the opportunity to experience our package as it is for the children themselves. Our research has shown reasonably clearly that anxious uneducated parents tend to have anxious uneducated children.

Throughout, I have stressed that the community should act in partnership with professionals. The medical profession does not by itself have all the answers! I remember at an AAWCH meeting listening with some humility to a doctor discussing epidemiology. What was most striking was that some of the greatest positive changes in health in our society have been as a result of sweeping public health measures, not necessarily medical intervention as such. He cited the disappearance of cholera because of clean water supply; the disappearance of smallpox because of inoculation; the lowering of maternal and perinatal morbidity because of antenatal screening; and improved nutrition and routine dental care.

RECOMMENDATIONS There are several things we must do:

A) We have to think prevention in these difficult financial times. Medical care--"picking up the pieces"--is just too expensive. It is also, particularly in my own sphere, time-consuming.

B) We have to decide there is a problem and that it can be rectified.

C) We have to find small measures which in several moves will prove effective, and then apply them early enough and broadly enough to protect our whole population, from before birth and throughout life.

I would like to share one final story. I was recently telling a friend about my three-and-a-half-year-old daughter, Sophie, who was romping on her bed and fell onto a sharp-edged bookcase, causing a gash in her forehead which bled profusely. On arrival at the doctor's surgery, she immediately asked which bed she would be sleeping in, and then asked for a nurse to come and clean up the blood from her arms and legs. She winced as the local anesthetic went into the cut but remained still and talkative, if pale, while the five sutures were inserted. Since that time she has given me precise instructions on how to look after the sutures, and when and how they are to be removed. The friend listened to my story with a wry smile on his face and at the end said, "Oh, yes, but of course, your daughter is very bright for her age, she lives witin the context of a medical family where such matters are discussed almost as a day-to-day routine, and I know that she has seen the film "Special People" at least twice!" "Yes," I replied, "and she has also played with my medical instruments and plays games of doctors and nurses with her friends and her dolls, but that is the whole point! Shouldn't every child have that advantage?"

In South Australia we believe that we are finally beginning

to get the mixture right. You see, prevention takes practice, and practice makes...well...it makes you think!

How Young Children Handle Difficult Events

by Patricia Lindquist, Ph.D.

Psychologist, Hillcrest Psychotherapy Center
San Diego, California

Joyce Robertson has taken fair issue with preparation when it adds to children's worries rather than helps with mastery. Taking examples from the lives of under-five-year-olds, Mrs. Robertson documents fantasies which become distorted and harmful when children cannot integrate an overload of information about bodies and illness procedures. She is calling to our attention the fragility of reality for youngsters in the under-five developmental phases.

This author's reaction, however, is to support the continuation of preparation of all children in knowledge of their bodies, in wellness and illness, and for the possibility of hospitalization. Specifically, this paper intends to provide more information about how young children handle difficult events. These remarks are intended to amplify the saying that "an ounce of prevention is worth a pound of cure." That is,

psychological immunization of children, even though there is a risk that they may catch some bit of the "germ" with which they are being inoculated, is more useful to adaptation and resiliency.

CHILDREN'S NATURAL DEFENSES

Anna Freud's monumental work (1) on developmental lines helps to clarify how young children use mechanisms of defense against danger, anxiety and unpleasure of all types. For example, babies use simple flight and denial reactions as insulation from danger on the outside. They close their eyes and fall asleep. At two- and three-years-of-age defensive activities proceed to more complicated combinations such as projection and introjection. As mental mechanisms grow, children have to defend themselves from the inside of their psyches as well as from outside stimuli. This is particularly true of the children from three- to five-years-of-age who are experiencing guilt as part of developing a conscience. This calls for more sophisticated defensive maneuverings which include repression (forgetting), reaction formation (bravery, disgust, independence), displacement (night terrors), and identification (imitation of others). Sublimation (turning fear into curiosity and learning skill) also emerges as mental mechanisms evolve from proprioceptive learning to concrete operational skills.

A developmental line has been identified which traces anxiety and some of the reasons for its arousal. Infants have archaic fears of darkness, noise and loneliness (caused by their weakness and immaturity). Toddlers fear abandonment, loss of mother, or loss of love of mother (caused by children's dependence on their caregivers for emotional resources). The three- to five-year-olds are fearful of disapproval (caused by the internalization of the parents' demands and the budding growth of

conscience).

The following are examples of how children handle anxiety about medical information by using protective defenses:

IDENTIFICATION When youngsters pretend to be the child life person or nurse who does the preparation procedures, they are identifying with her. Linnea and Jessica, both three years of age, played "nurse" after attending a Health Fair in the local shopping center. They bandaged their dolls, listened to hearts and bellies, and felt foreheads, then "gave" injections to "make it all better." They were imitating the behaviors and talk of the nurse-educators who gave the demonstration to families at the Fair. Identification and introjection are related at this age. A mental or physical quality is "appropriated" by children and treated as it if were a part of themselves. Consequently, no amount of talk from their feminist mothers could convince the girls that they could be doctors as well as nurses. In the concrete fashion of three-year-olds nurses are the fair ladies who tell children how to take care of themselves when they get sick. Linnea and Jessica were also identifying and introjecting mommy when she does the nursing for an ill little girl. They sounded just like mommy as the dolls were scolded and told to "stay in that bed like I told you."

REPRESSION is often the defense of toddlers who are coping with the complicated tasks of separation-individuation, the emergence of their individual selves. When mother goes out and stays away so long, toddlers "forget" that she does come back and they have a joyful reunion. Instead, when mother is ready to leave toddlers are tearful and clinging. Repressing the anxiety about abandonment causes them to forget the memory of the happy returns. It is no wonder children use such a powerful emollient as banishing the anxiety of mother leaving. Their days are full of issues such as learning how to absorb inner hurts ("I am a bad

girl" as well as outer ones ("Don't mess"). They often must tolerate the infantile sense of being "the one and only" slipping away. They are also coming to terms with the revelation that they are a separate human whose caregivers are not as omnipresent as they had believed them to be.

There is almost no way to "prepare" toddler age children. They live in the "now" of intense attachment to their mothers. They are preoccupied with separation and abandonment. Youngsters who cope with the loss of their mothers while separated from them in the hospital often reveal the toll of this coping later. They regress and "forget" accomplishments such as talking, toilet training, and sleeping alone. Repression as a coping device can rob children of their learning. They banish the bad memory of mother being gone and other capabilities get banished also. This is why toddlers and mothers should remain together during hospitalization. Preparation at this age means helping mothers to be with their children at the actual time of the events or arranging for mother substitutes (when necessary) who are the same reliable people during the time when the mothers must be away.

REACTION FORMATION is a defensive maneuver born of the many demands around toilet training. As children take on the attitude of grownups that clean and tidy is admirable and dirty is disgusting, they often overdo the "disgust" reaction. For example, when four-year-old Peter, who had been clean and dry both day and night for over a year, entered the hospital for hernia repair, he was told that after surgery he would be expected to use a special pan so that the nurse could check his voiding and bowel movements. When the time came for Peter to perform on the pan he became indignant, then flatly refused. He would "hold it," he said, and he did. He suffered from the cramps of a distended stomach but would not "let go" of the bowel movement until he had been home for several hours.

Peter's reaction to toilet training had been accepting. In fact, he had trained easily. But he had also introjected mother's attitude about the "dirty, yucky poo" that needed to be swiftly dispensed with in the toilet. In the hospital Peter did not want to show this part of him to the nursing staff. He wanted them to admire him and not to witness his motions. If mommy wanted to flush them quickly away, why would they want to keep the mess "for checking?" It did not make sense to him. Peter's reaction formation was such (feelings of shame and disgust about his bodily products), that he was willing to suffer stomach cramps rather than provide them for showing.

Children who are being toilet trained, or who have just successfully completed that hurdle, become anxious around toileting activities in the hospital. Showing them the toilets, bathrooms, urinals and bedpans and explaining their use in preparation is a kind of therapeutic play intended to reduce their concerns. Modeling with dolls for younger children is a most serviceable play about the meaning and use of anal products.

PROJECTION Another protective covering is the use of projection. Three-year-old Mark also attended the Health Fair and played with the women in white smocks who showed children injection needles and let them practice needle play. Later on in the day he was fearful and wanted to be carried when a large group of individuals from a religious sect, dressed in white gauze garments, passed by. He protested to daddy that they "don't like me." Mark's fears about being "got" by needles were overstimulated and he projected this onto the color white and the unusual group of strangers. The next day he insisted that daddy wear a print shirt rather than a white shirt. Mark said that the white shirt was "bad."

DISPLACEMENT is also a camouflage for anxiety. Juanita, four years old, spent a whole morning behind closed doors bathing her teddy in a plastic bin and angrily jabbing cotton swabs into its eyes and ears. She was heard telling the toy to "be a big girl and just sit still for this." Juanita had been camping with the family when a dust storm covered them all with gritty debris. She had to be washed for a long period to clean her face and body of dirt. Juanita was displacing her anger onto the toy for all of the bathing and swabbing. A friendly nurse who smiles at a child patient in the doctor's office, only to be slapped at or received with a squeal of terror, is often getting projected or displaced behavior from an anxious child.

The ways in which children handle anxiety and danger-provoking events will, after time and with rewarding reinforcement, become the consistent, habituated responses which make up children's character style.

However, young children's defenses are not reliable. As Mrs. Robertson indicates, little children's moods do change often. They become preoccupied, troubled, and fearful in their efforts to master reality. There is a short-lived quality to their abilities to defend themselves against internal and external dangers. Young children can be said to be "trying on" protective behaviors. These behaviors are more like coping mechanisms. Coping is less habituated, less entrenched and intended to deal with psychological emergencies rather than full blown, well-organized character defenses

For example, five-year-old Sean was told that his colds and chest congestions would stop as soon as the doctor could remove his tonsils. He would have to go to the hospital when it was convenient for his pediatrician. Sean wondered aloud why mommy could not take his tonsils out instead, or why his nice kindergarten teacher could not do it, or why he could not do it

himself. Then he asked mommy to call the doctor and see if "he was convenient after supper." Sean will continue this line of reacting if his mother is amused and makes a display of her reactions to his cute remarks. If she explains, instead, that taking out tonsils is a special job for doctors and that there is a special place in the hospital for that to happen, Sean will likely drop the first coping maneuvers and develop curiosity about the "special" way his tonsils get out and the "special" place in the hospital. He may even become interested in the doctor and decide that he will be a doctor and take tonsils out. After the operation, Sean may develop an affection for the doctor and ask to visit him or to have the doctor come see his room at home.

Falling in love with the doctor is a special form of coping often used by ill children. They are identifying with the aggressor (who becomes "good" not "bad"). Even though doctors unavoidably hurt sometimes, they are very "nice" and "love" little boys and girls. This is a form of accomodation to Sean's anxious reaction about the operation. It is the response of youngsters who are learning that parents can hurt, too, in their role as ministrators and disciplinarians. They learn to love the parents who are sometimes "bad" and who "hurt" and this is transferred onto other adults who hurt in the name. of "betterness." Hobbies, talents and careers can emerge from these early identifications and efforts to cope with nonpleasurable events. This is certainly more likely when adults have been soothing and comforting about the activities which cause pain and anxiety. (2)

Youngsters' fears do become overly magnified and psychologically distorted. Without acknowledging them, these terrors can split off from the real events and become internalized as "bogey men." Then they must be defended against in neurotic ways.

Children now are provided information about hospitalization and medical procedures through school health programs, children's shows on television, and public information teaching, including field trips to hospitals for preschool children. Activities such as these provide them and their parents with information about the body in wellness and in illness, thereby preventing more devastating psychological and emotional consequences if a crisis should arise.

This education is sometimes called "psychological immunization," a concept developed by Gilbert Kliman at the Center for Preventive Psychiatry, in White Plains, New York. (3) Kliman explains that it is the paradox of immunology that, unless children are exposed to the kind of bacteria that could make them ill (though not in large enough quantities actually to bring on the disease) they will not develop immunity to the bacteria. Small and safe doses of bacteria provide the opportunity to build up physical immunity. Kliman uses this medical image as a metaphor for the need to have adults who will explain reality and guide children to truth even if it is painful. A little at a time, it is straightforwardness that gives children the internal strength to deal with things not as they imagine (and distort) them, but as they are.

While overstimulation does not help children to cope, some parents protect their children too assiduously from outside experience on the grounds that the exposure might be too hazardous. This kind of caution can deprive children of the challenge required to stimulate their adaptation to a complex, changing, and sometimes potentially hostile world.

Young children are continually exposed to toxic experiences. A parent becomes mentally or physically ill and is absent or unavailable to the child for a long period of time. A sibling is

in an accident or dies. The house burns down. The child witnesses violence or is subjected to abuse. The parents separate, or consider a divorce, or divorce. A parent loses a job and the family resources are slim. The family moves to another city or another house. A pet is killed. A new baby appears and corners the parents' attention. The family is caught in a snowstorm, flood, or earthquake. One can hardly list all the potentially disorienting events which occur to, or around, chldren in their daily lives.

Youngsters who are exposed to small doses of potentially disturbing experiences, and not more than they can handle at certain stages of development, with the repertoire of coping mechanisms generally understood, have more opportunities to develop useful defensive activities. This underscores the need for children to be exposed to simple concepts of preparation for illness, hospitalization, and medical procedures. Organized and monitored information has more of a chance to "take" (like a vaccination) than haphazard or crisis dialogues.

Educators who prepare children for noxious experiences presuppose that a supportive adult, usually the children's parents, will be in the audience. That adult presence must be considered a precaution.

The focus of activities is on participation when young children are being prepared. Concrete activities which stimulate seeing, hearing, touching, and tasting cumulatively add to awareness and guard against "too much, too soon."

Preparation play is not incidental play. It is organized as therapeutic play. It is a prophylactic event designed to provide materials and talk in order to encourage children to associate positively with an event that may be noxious or frightening. As therapeutic play it can be a form of "continued mothering" when

children are in stress. This likens preparation activities to the idea of a "transitional object," a calmer and soother which becomes a stand-in for mother.

Therapeutic play has to be repeated to "get in" and preparation play is often repeated by children as they gain distance from the actual event of hospitalization. Adults who join children in such play activities have the opportunity to be in touch with their own infantile selves and feelings. Keeping children clear about the difference between fantasy and what is real aids coping. That is the underlying purpose of preparation.

I am grateful to Joyce Robertson for her clinical examples that urge caution in the preparation of young children for illness and hospitalization. I know that no matter how well I find simpler ways to explain complicated things children will misunderstand some part of the explanation. I cannot help this fact of psychological life. Layers of communication, another coating of talk, may provide the moment that is useful. That is why I prescribe more thoughtful preparation dialogue rather than less. Each time over difficult ground children can bring their versions of things closer to reality.

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The Policies of Three Child Advocacy Groups on Nonpatient Preparation

by Pat Azarnoff, M.Ed.

Editor, Pediatric Mental Health and
Director, Pediatric Projects Inc
Santa Monica, California

Three major advocacy groups for children in health care have provided information on preparing nonpatients.

IN GREAT BRITAIN The National Association for the Welfare of Children in Hospital (NAWCH, London, England) works to sensitize parents and staff about the emotional needs of hospitalized children and to encourage hospitals to set policies that enable parents to be with their hospitalized youngsters.

Nearly one million children are hospitalized annually in

Great Britain. Half of these hospitalizations are emergency cases which are caused by accidents. Two-thirds of the children hospitalized will have surgery. By the time they are five years of age, over a quarter of all children will have been hospitalized. (1)

NAWCH began a three-year research project in 1977 on preparation of children for hospitalization. The study was designed to develop and evaluate highly visual educational materials which help to prepare young children for hospitalization, and to assess ways in which the materials could be used. The project developed storybooks for young children about going to the hospital, to the outpatients, and to X-ray, as well as games and other activities to help children learn about health care. (2)

However, after the NAWCH annual conference in November 1980 (which had the theme, "Preparing Young Children for Hospital") some members expressed concern about formalizing plans to use the materials and talk about hospitals to groups of young nonpatient children.

Some of the letters appearing in the NAWCH newsletters (3, 4), for example, urged caution on conducting hospital visits for schoolchildren. Organizers of the visits were said to "have no idea of the possible effects of such visits upon the child visitors let alone on the children in the wards visited." The writers also stated that only parents should "be the ones to tell their children about hospitals. Even if some do it well, some do it badly, and some not at all the only safe approach is to let parents do it their own way."

Local NAWCH groups reported their experiences with the visits, which seemed to confirm the view that the children's feelings were sometimes not recognized or dealt with. For

example, one group reported (4) "Adults helped to make...hospital beds from shoe boxes with material scraps for bedding. The patient and teddy...and the nurse...were also (constructed.) All the children wanted to participate and many of the mothers commented on how these 'sets' had been played with at home. What surprised us most was the way in which two of our difficult children responded. Not only did they painstakingly make the sets but afterwards sat quietly playing with them until home-time. Neither had ever concentrated on one activity for such a period of time. We learnt later that both had experienced a stay in hospital."

In June, 1981 NAWCH and the Robertson Centre held a study day, where officials and members discussed the plans to promote visits to groups of young children. Dr. Dermod MacCarthy, Joyce and James Robertson, Juliet Hopkins, and Susan Harvey supported the view that talking to young well children about hospitals was well-intentioned, but potentially harmful. The visiting NAWCH member could not know the emotional history of the children and, therefore, could not avoid aggravating existing anxiety or promoting new fears. Not even the play leader could know the children's anxieties. The parents, however, are in the best position to know the children's experiences and reactions, comprehension and level of development. NAWCH should be a source of help, but not a replacement for parents, they argued. (5)

The Executive Committee of NAWCH concluded that NAWCH members should not themselves give talks to children in preschool groups. Instead, they recommended that NAWCH members give guidance to adults, such as parents, teachers and play group leaders, who have contact with the children. However, they suggested having medically-oriented play materials in play groups so that children could use them in their ordinary, undirected play about medical experiences. (6)

IN THE UNITED STATES The Association for the Care of Children's Health (ACCH, Washington, D.C.), an international group of health professionals and parents, works to humanize health care for children and their families. The Association's publication for teachers (7) encourages helping children "develop positive attitudes toward health care, an understanding of hospitals and illness, and a sensitivity to children who have been hospitalized or who have a chronic condition."

Among the concepts the ACCH publication promotes are:

"Hospitals are places where people can go when they are sick.
Hospitals help you get better so you can go home.
Hospitals have many caring people to help make your stay in the hospital easier.
Doctors and nurses are people who help you stay well and take care of you when you are sick."

When a hospitalized child returns to school, the publication suggests that teachers can ease the adjustment by inviting nurses and/or other hospital personnel involved with the child to:

"Visit the class and answer questions,
Explain the illness or condition, and
Bring any special equipment, therapeutic aids or prosthesis to acquaint the class with the hospitalized child's experience."

Classroom activities, continues the publication, could also include dramatic play visits to a "doctor's office" or "hospital," using replica medical equipment. Supervision by the teacher and participation in the play is encouraged to provide insights to the teacher about children's feelings, experiences, and understandings. Tours of a hospital or classroom visits by hospital staff or volunteers may be arranged.

In another ACCH publication (8) the Association recommends the "health care setting should develop out-reach programs which include visits to pre-schools, kindergartens, and other child groups to present interesting and relatively non-threatening aspects of hospital and health care." It suggests that medical personnel be sent to participate in the meetings of parent-teacher associations and parent groups, explaining "the importance of attention to the psychosocial and emotional aspects of health care for children."

In addition, ACCH sponsors a popular, nationwide "Children and Hospitals Week" each March. They distribute news releases for the general public and send literature to hospitals encouraging sensitivity to children's hospital experiences. Many hospitals respond with open house tours for all children, displays of equipment, talks by staff, and the showing of films and slide/tapes about their facilities and services for the families who attend. Some hospitals hold health fairs in shopping malls, provide speakers for television and radio interviews and distribute pamphlets about hospitalization to parents. (9)

IN AUSTRALIA The Australian Association for the Welfare of Children in Hospital (AAWCH, Parramatta, New South Wales) educates the public and professionals about the need for hospitalized children to have a parent close by and to have play activities, and promotes home treatment of sick children wherever possible.

"It is only since 1979, The International Year of the Child, that (Australian) hospitals opened their doors to groups of young children, other than patients. During that year the Association initiated a nationwide 'Children in Hospital Week' that

encouraged hospitals to build stronger ties with their community." (10)

A large number of schools and preschools responded so "quite a number of hospitals...organized visits of groups of chldren, including children under five years of age, to continue on a year-round basis. The quality and content of such visits vary, as does the degree of involvement of school or preschool teachers and of parents." (10)

Within AAWCH the South Australian Branch assembled and distributed Hospital Play Kits to kindergartens. They also wrote, published and distributed a storybook for young children about going to the hospital. (11) The New South Wales Branch sends a member who is a registered nurse to visit schools and conduct hospital classes.

AAWCH "does not have a stated policy on how to prepare young (i.e. under five) healthy children for possible hospitalization." (12) The National Organiser, Doris Hart, agreed to share her opinion, however. She says that "young children's experiences of hospital should arise naturally through family events. When a child is admitted to hospital, his best insurance policy against the inherent dangers of hospitalization is the presence of a loving, well prepared parent able to stay with him and share his care with an insightful staff. Therefore, I hold the gravest personal doubts about the usefulness of hospitals' 'guided tours' as a method of preparation for healthy children under five." (12)

She gives the analogy of preparing children for a death. "When death happens in a young child's family (or even when a child suspects he may himself be dying) the experience can totally devastating to the child. Nevertheless, we do not attempt to prepare healthy young children for death. We know

that the ability of the child to cope and the extent of any damage resulting from the event will depend on how the adults involved in his life are able to handle the situation themselves and with what insight and resourcefulness they are able to respond to the child's needs.

"The same could be said of the hospital experience. Preparation of healthy young children for possible hospitalization should, therefore, only take place as and when the subject arises in the natural course of events, and would need, on such occasions, the active involvement of the parents and of the professionals closest to the situation." (12)

When the Association was founded in 1973 children were not being permitted to participate in the event which brought the family into the orbit of the hospital, Ms. Hart reports. When a new baby was born "children were not allowed to visit mother. She completely disappeared from their lives for the period of hospitalization. Hospitals displayed notices refusing admission to children under twelve years of age. When...anyone at all close to the child was hospitalized children were barred from visiting. Thus they had no means of knowing for themselves where the patient was and what exactly was happening. Instead they were left to their own fantasy worlds fuelled by past experiences (possibly a grandparent who had entered hospital and never been seen since or a neighbor who had lost a limb) and by what they might overhear from unwitting adult conversation (e.g. 'They took some more blood.' 'She was cut from here to here.' 'He might lose his leg.' 'Mrs. X died of the same thing.')

"In short, the refusal to allow children into hospital in such circumstances not only increased their apprehension but built into them a general fear of hospitals which boded ill for the child's own admission should that become necessary in the future. Equally importantly, these hospital policies deprived

children of essential, natural learning experiences associated with significant events in their family life." (12)

AAWCH campaigns for "the right for children to visit hospitals with family members who would be able to protect the child by dealing with the experience in a natural way, at the level of the child's own understanding." They also advocate that "through cooperation with hospitals it should be made possible for parents, child care workers and kindergarten teachers to acquire background knowledge to enable them to meet children's needs as they arose, naturally, in the normal course of events." (12)

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Practices and Studies in Nonpatient Preparation

by Pat Azarnoff, M.Ed.

Editor, Pediatric Mental Health and
Director, Pediatric Projects Inc
Santa Monica, California

Many preschool children will eventually come to the medical setting for emergency, inpatient or outpatient care. A prior encounter with the medical center in which no treatment is given or demands made may result in fewer adjustments to make when treatment is given, according to proponents for nonpatient hospital tours. Visits to preschools by medical personnel and hospital tours are also seen by some as part of a hospital's responsibility to provide community health education. (1)

Nurses, play specialists and volunteers who lead such programs have been impressed with the many facts and feelings children have stored from previous visits to doctors' offices or

clinics, from the experiences of shots and other bodily intrusions, from the mysteries and magic of a hospitalization, and from seeing illnesses in other family members. According to these advocates, children lighten some of their mental and emotional burdens when given the stimulus of a medical setting, and the time and permission to express their feelings.

Others believe the length of time for a tour or preschool program is too short to teach as well as to observe what the children have learned. In the typical one-hour hospital tour children are subjected to so many sights and sounds that they find it difficult to understand and integrate them. Sights and sounds cannot be completely controlled so that tours have random, sometimes negative, stimuli which may confuse, overwhelm and frighten young children.

PRACTICES IN THE UNITED STATES Tours of hospitals are a widespread practice in the United States. (2) They are designed to help children become familiar with a hospital before they need its services. As part of studies on preparation practices, the author has personally observed many patient and nonpatient tours in hospitals throughout the United States, and interviewed colleagues about the tours they offer. Most tours last one hour, include children over the age of four years, are conducted in groups of ten to thirty people, and have one to four adults participating. They are intended to familiarize children with numerous aspects of the medical setting to relieve fears and increase interest.

Mary Donnelly-Crocker, of the Patient Services Department of Huntington Memorial Hospital (Pasadena, California), for example, wrote to teachers inviting them to bring children on a hospital visit: "When children enter the medical world they are often at a loss to understand what is happening to them....If, however,

children have some tools for understanding this new environment and the events that occur within it, they may be able to master their anxieties and fears and emerge with a strong sense of their own well-being." (3)

Their "Let's Visit the Hospital" program is designed to provide an educational experience for preschool and day care groups, their teachers and parents. It includes a twenty-minute slide show with live narration geared to young children, the use of medical equipment for play, and a ride on a gurney or wheelchair. In addition, some of the children dress up in surgical clothes and all children receive a finger cast and surgical mask. The groups, including up to twenty children (with one adult for every four) are then taken through the pediatric unit, for a total visit of about one hour.

At Tod Babies' & Children's Hospital (Youngstown, Ohio) tours have been offered since 1977. Kathleen D. Vrabel, Director of the Child Life and Education Department, believes that the tours convert some of the children's fantasies to tolerable reality, and the parents are relieved and transmit their calmer mood to the children. Staff, seeing children's reactions, become more sensitive to the need for preparation. (4)

The tours are scheduled well in advance and guidelines reviewed with the adult in charge. This gives staff members a chance to know ahead of time if there will be a child on the tour who is, for examples, afraid of elevators or who has a particular fear regarding hospitalization. The staff also give the adults who will accompany the children a brief summary of the areas to be viewed so they can discuss it with the children ahead of time.

Ms. Vrabel writes that "countless numbers of times we have approached child patients (who have taken the tour as nonpatients) to explain surgery or a diagnostic test and heard

them say, 'I know a lot already...I'm not afraid.'" "It is imperative, however, that the person conducting these tours is educated as to the needs of these children, knows WHAT to say and HOW to say it."

Tours are sometimes limited to a particular time of year or day of the week. St John's Hospital & Health Center (Santa Monica, California) had a summer program of hospital tours for children three years of age and older. (5) A volunteer led the groups through the admission area, radiology, and clinical laboratories. In the pediatric ward a nurse answered the youngsters' questions and medical equipment, such as stethoscopes and blood pressure cuffs, was shown.

Hands-on experience is often included in preschool tours. When Tucson Medical Center (Tucson, Arizona) started tours, a nurse led children through the pediatric unit, showing a crib, how beds crank up and down, and the playroom. Children listened to their hearts with a stethoscope and used the IVAC thermometer, listening for the bell and watching the numbers change. Then a film was shown. (6)

Volunteers often are tour guides. At Mercy San Juan Hospital (Carmichael, California) two auxiliary volunteers and three adults from the visiting group brought a maximum of thirty children through the PBX office, computer system room, admissions offices, emergency room, pharmacy, laundry, dietary, supply/purchasing, playroom, by the operating room (but not in), and the nursery through the viewing windows (the all-around favorite, according to the letters the children wrote afterward). They played with stethoscopes, masks, syringes and an intravenous set-up, which were used to explain medical care and clarify misconceptions about medical instruments. The pediatric unit itself was not included. (7) These tours are popular: By October the entire school year of once-a-week tours is scheduled, since

many kindergarten, first and second grade teachers arrange visits.

In some hospitals young nonpatients, such as siblings of the patient and presurgical patients are grouped together for a tour. Mary Bridges Children's Hospital (Tacoma, Washington) has offered such tours as part of its Family Life Program. (8)

Tours with follow-up for the children's teachers are offered at a few hospitals. The staff at the University of Michigan's Mott Hospital (Ann Arbor, Michigan) have said that checking with the teachers afterward to see what the children learned and how they felt about the tour is an important part of the preparation. If any teachers were not planning to conduct a discussion or play sessions about the experience, the hospital's staff may be able to help them design appropriate activities. (9)

A number of hospitals have both tours and in-school programs. The Children's Health Center (Minneapolis, Minnesota), for example, has a "Health and Hospital Prechool Program." Volunteer teaching teams and the children's teachers use a four-unit teaching guide to talk with children at school about their concepts of hospitals. Then they bring the children on a tour of a hospital or neighborhood clinic. (10)

To avoid bringing children to its real pediatric unit Wheeling Hospital (Wheeling, West Virginia) offered second-grade classes a one-hour "Peek at Peds." This included a tour through the simulated pediatric nursing unit in the Nursing Arts Laboratory at the School of Nursing. Children tried on gowns, rode a cart, and handled selected medical equipment. (11, 12)

Some people believe it is inappropriate to bring well children to the hospital to prepare them. Emma Plank, one of the early leaders in emotional care of children in health settings,

has written (13) that hospital tours are inappropriate and recommends school visits instead:

"Preparation through group visits from kindergartens or schools has doubtful value. The children either fail to see the things they might experience as patients, or they make observations which, depending on their personal anxieties, they may misinterpret. They tend not to ask really crucial questions, owing to their unease in such a strange setting; and unasked questions cannot be noticed or elicited. This is especially true of children under six or of those from less articulate population groups. Specific and personalized preparation is therefore the method of choice. If schools want to familiarize children with the hospital as a community institution, a better way would be to have a professional staff member visit the school and explain essentials with slides and open a discussion on the children's 'home ground,' i.e. in their classroom."

Some hospitals no longer offer tours but send materials and/or staff to schools. The outpatient Child Life Program of the University of Colorado (Denver, Colorado), for example, decided tours consumed too much staff time, the groups were too large, and it was difficult to observe and interpret children's reactions to what they saw. Although they stopped the tours, they sent educational materials to teachers for background. Project HELP (Hospital Education for Little People) materials enable school nurses and teachers to answer children's questions and respond to their concerns. (14, 15)

James Whitcomb Riley Hospital for Children (Indianapolis, Indiana) also sends staff to schools to orient children about hospitals. If a tour is requested, however, they prefer that children visit an acute care hospital where they are likely to be affected less negatively than at the university hospital. (16)

Some hospitals now offer neither. National Jewish Hospital and Research Center (Denver, Colorado) had preschool tours for a while. Now they believe the message they want to present through their Community Relations program, about their research and services, is better understood by older children. (15)

Community outreach programs, yet another approach, often take the form of health fairs for children. This enables university departments, agencies, and health centers to cooperate in offering information and hands-on experiences for children and their families. One such fair provided participatory exhibits in an inner-city park, with experiences, materials, and conversations about health care in English, Spanish and Asian languages for predominantly non-Caucasian children and families. Since there are few preparation services for non-English speaking children (patient or nonpatient) (2), its purpose was to reduce children's fears, promote greater understanding in parents of their part in their children's emotional health, and increase awareness of families' emotional needs when their children are in health care. (17)

PRACTICES IN CANADA There are few school tours through Canadian hospitals (18), although they have been offered at Children's Hospital of Eastern Ontario (Ottawa, Ontario), Izaak Walton Killam Hospital for Children (Halifax, Nova Scotia), and the Hospital for Sick Children (Toronto, Ontario), among a few others.

There are almost no preparation programs in schools, although The Izaak Walton Killam Hospital has had a School Suitcase program, medical materials sent to preschools with guidelines for their use. (19) They sent a staff person with the materials but found it too time-consuming. Child Life Director Linda Skinner says the staff feels a leader is needed who can answer questions and observe behavior, and they are currently trying to decide

whether to continue the program.

Frances Ricks, of the University of Victoria (Victoria, British Columbia), who co-authored a study of Canadian child life programs (20), says it is rare for staff to go into preschools or playgroups. (21)

Programs for nonpatients are also described in papers in Canadian journals by Smith (22) and Stainton (23). And a booklet was developed for teachers' use by Elizabeth Crocker that details what can be learned by hospital tours and follow-up school studies. (24)

PRACTICES IN NEW ZEALAND AND AUSTRALIA On a month's fellowship visit to New Zealand and Australia to study preparation practices (25) the author observed in many hospitals and interviewed numerous staff, with follow-up correspondence. Only a few hospitals in either country offered preparation for hospitalization, and fewer still invited schoolchildren to visit or sent staff to schools.

However, the Australian Association for the Welfare of Children in Hospital provides a Hospital Play Kit to kindergartens in one area. It includes real and simulated medical instruments and a nurse's cap in a simulated doctor's bag. Ideas are given to teachers on ways to use the kit for dramatization and discussion. A study (26) on the influence of the kits on children's understandings and feelings about medical care and hospitals was considered to demonstrate the effectiveness of the kits.

STUDIES The research literature on nonpatient preparation is sparse. Few programs have been systematically evaluated, although a number have been described. Evaluation of services has usually been through informal comments from parents and

teachers, observations by staff, or brief questionnaires to small groups. (1) Most decisions to have such a service, change it, or suspend it have been on the basis of reasoned clinical judgments, child development theory, or budgets.

Three nurses at Good Samaritan Hospital (Phoenix, Arizona), for example, reported that since they visited kindergartens to teach about hospitals 76 of these children have been admitted to local hospitals. The nurses observed that the children who were in the program were less anxious than most children their age. (27) On the preparation visit the nurses wore various uniforms, sat on the floor with the children, and listened to the children's own stories of medical experiences (unusual in preparation of nonpatients). Then they presented medical equipment and invited discussion and role play. Finally, they showed slides of a child in the hospital for surgery.

When any of the children was admitted to a hospital the school nurse notified the visitor nurses so that the experience could be evaluated. The children who were prepared "seem to have fewer anxieties, seem more familiar with their environment, and are generally cooperative....Physicians remark that these children are particularly helpful in surgery, wanting to hold their own mask while falling asleep. They offer little resistance to safety belts in the recovery room."

Some school programs reach many children. One program developed at Children's Hospital (St. Paul, Minnesota) for second-graders sent a nurse and volunteer to the classroom to explain what happens in a hospital. They talked about pain but also about the fun children can have playing. A slide show depicted what happened to one child from admission until discharge. Then they talked about surgery, dressed a child in surgical garb, and displayed small medical equipment. In its first year the team spoke to over 19,000 second grade students

and toured over 4,000 children of all ages through the hospital. (28) Later, the program expanded to include a talking teddy bear programmed with tape cassettes for kindergarten and first grade children who tour the hospital admissions and emergency departments.

How many hospitals offer nonpatient preparation? In research by Ricks & Faubert (20) Canadian child life workers did not list preschool education among their activities.

In a survey by Mather & Glasrud (29) 60-79% of the 152 U.S. hospitals responding to their survey conducted well-children tours and orientations, among other activities. One half or less conducted "community outreach/educational programs."

In another study (2) a survey questionnaire was sent to U.S. hospitals serving children and site visits were made. Since children are emotionally affected by the illness of their siblings (30) the survey included a question about whether or not siblings could visit and what other services were available to them. Of 313 hospitals offering preparation to pediatric patients, 74 answered the question about siblings. Of those, 31 included siblings on tours, 22 included siblings in all preparation events, and 21 said siblings could visit the patient.

Over 200 hospitals were identified that offered preparation to other nonpatients:

Number of Hospitals Preparing Nonpatients
(Some offer more than one service)

School group tours	135
Youth group tours	60
Open Houses	5
Prepare at clinics	5
Community outreach	12
Staff visits schools	21
	238

Since completion of this study additional hospitals offering school group tours and school visits were found.

The feelings and ideas of nonpatients have been studied. (31) Irwin & Kovacs analyzed the drawings and stories of 30 hospitalized and 30 nonhospitalized children, ages 6-12 years. Using a variety of projective techniques they determined children's feelings and ideas about hospital procedures.

Nonhospitalized children were more removed from reality, gave more fanciful stories that included heroic acts such as being an astronaut or winning a game. Fantasy, as a defense, seemed to be more available to them than to the hospitalized youngsters, who showed great fear of personal injury, lessened self-esteem and increased dependency.

Nonhospitalized children told more positive stories overall. Even the dreams they told about were less sad and fearful. They explained injuries in a more matter-of-fact way, sometimes with humor.

The authors of the study suggest that expressive activities such as drawing and storytelling can be an important and powerful

aid to all children, since both hospitalized and nonhospitalized children voluntarily used the research nurse's help beyond the needs of the study to talk about their feelings.

Since there is great interest in nonpatient preparation but little research, this seems a significant area for practitioners to re-examine and for researchers to pursue.

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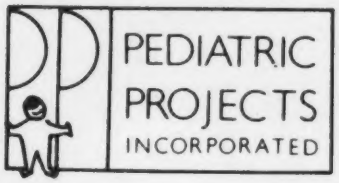

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Rhode Island Hospital
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Mental Health Study Center
National Institute of Mental Health
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